

APPENDICES

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APPENDIX A

Introductory Person-Centered Plan Template
Complete Person-Centered Plan Template
Person-Centered Plan Consumer Admission Form and Instructions
CAP-MR/DD Plan of Care
CAP-MR/DD Cost Summary

INTRODUCTORY PERSON-CENTERED PLAN

Name: (Preferred Name):	DOB: / /	Medicaid ID:	Record #:
Person's Address: (Street/mailling address) (City/State/Zip)			Telephone #: (Home) () - - (Work) () - -
Date of Plan: / /		Allergies: 1. 2. 3.	
<i>(NOTE: Date of plan is the 1st date of contact with the Qualified Professional who will complete the Introductory and/or Complete PCP.)</i>			

ACTION PLAN

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others.)

--

Where am I now in relation to this outcome?

--

SYMPTOM/OBSERVATION (List symptoms/observations based on preliminary knowledge):

Short Range Goal		Support/Intervention to Reach Goal		Who Will Provide Support/Intervention/ Service?	Support/Service & Frequency
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal		
/ /	/ /				
/ /	/ /				
/ /	/ /				
Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued					

SYMPTOM/OBSERVATION:

Short Range Goal		Support/Intervention to Reach Goal		Who Will Provide Support/Intervention/ Service?	Support/Service & Frequency
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal		
/ /	/ /				
/ /	/ /				
/ /	/ /				
Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued					

Name:

DOB:

Medicaid ID #:

Record #:

CRISIS PREVENTION/CRISIS RESPONSE (CONTINUATION)

(Use this form or attach a crisis plan that includes the required elements below.)

Contact List (Include names as applicable, relationship and direct phone numbers or extension.)

First Responder:	Telephone #: ()- -	Consent/Release of Information: <input type="checkbox"/> Yes <input type="checkbox"/> No
Legally Responsible Person:	Telephone #: ()- -	Consent/Release of Information: <input type="checkbox"/> Yes <input type="checkbox"/> No
(If applicable-Attach a copy of any applicable supporting legal documents)		Date of Legal Document: / /

Natural/Community Supports:

Name:	Telephone #: ()- -	Consent/Release of Information: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name:	Telephone #: ()- -	Consent/Release of Information: <input type="checkbox"/> Yes <input type="checkbox"/> No

Professional Supports:

Name:	Telephone #: ()- -	Consent/Release of Information: <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician:	Telephone #: ()- -	Consent/Release of Information: <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Psychiatric Inpatient /Respite Provider:	Telephone #: ()- -	Consent/Release of Information: <input type="checkbox"/> Yes <input type="checkbox"/> No

Other Professional Supports:

Name:	Telephone #: ()- -	Consent/Release of Information: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name:	Telephone #: ()- -	Consent/Release of Information: <input type="checkbox"/> Yes <input type="checkbox"/> No

All Current Medications <i>(* Update and revise list of medications anytime there is a change)</i>	Dose:	Frequency:	Reason for Change:	Date:
1.				/ /
2.				/ /
3.				/ /
4.				/ /
5.				/ /
6.				/ /
7.				/ /
8.				/ /

Name:

DOB:

Medicaid ID #:

Record #:

CRISIS PREVENTION/CRISIS RESPONSE (CONTINUATION)

(Use this form or attach a crisis plan that includes the required elements below.)

Advanced Directives: (Advance Directives allow you to plan ahead for care in the event that there are times that you are unable to speak for yourself).

☐ Yes ☐ No I have a Living Will.

☐ Yes ☐ No I would like one.

☐ Yes ☐ No I have a Health Care Power of Attorney.

☐ Yes ☐ No I would like one.

☐ Yes ☐ No I have an Advanced Instruction for Mental Health Treatment.

☐ Yes ☐ No I would like one.

Emergency Contact or Next of Kin:

Relationship to Person:

(Address):

(Street/mailling address)

(City/State/Zip)

Home Phone: ()- -

Work Phone: ()- -

Crisis Plan Distribution List:

1.

2.

3.

4.

5.

6.

7.

8.

	(DSM* Code)	(Diagnosis)	(Diagnosis Date)
Axis I			/ /
Axis II			/ /
Axis III			/ /
Axis IV			/ /
Axis V			/ /

Name:

DOB:

Medicaid ID #:

Record #:

SIGNATURES

REQUIRED for Medicaid funded services. RECOMMENDED for State funded services.

My signature below confirms that medical necessity for services requested is present, and constitutes the Service Order(s):

Signature: _____

Date: / /

(Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)

Annual review of medical necessity and re-ordering of services is due on or before: Date: / /

Person Receiving Services:

- I confirm and agree with my involvement in the development of this person-centered plan. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for my plan.

Signature: _____

Date: / /

(Required when person is his/her own legally responsible person)

- **The following signatures confirm the involvement of individuals in the development of this person-centered plan. All signatures indicate agreement with the services/supports to be provided.**
- **For state-funded services, if the first signature box on this page is not completed, the signature of *the Person Responsible for the Plan* in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.**

Legally Responsible Person Signature: _____

Date: / /

(Required, if other than the individual)

Person Responsible for the Plan Signature: _____

Date: / /

(Required)

Other Team Member Signature: _____

Date: / /

Other Team Member Signature: _____

Date: / /

Annual Review of medical necessity and re-ordering of State-funded services is due on or before:

/ /

COMPLETE PERSON-CENTERED PLAN

Name: (Preferred Name):	DOB: / /	Medicaid ID:	Record #:
Person's Address: (Street/mailling address) (City/State/Zip)			Telephone #: (Home) ()- - (Work) ()- -
Date of Plan: / /		Allergies: 1. 2. 3.	

Participants Involved in Plan Development

Name (person to whom this plan belongs): Role: <input type="checkbox"/> Participated in @ least 1 planning meeting <input type="checkbox"/> Provided written input <input type="checkbox"/> Telephone participation <input type="checkbox"/> Invited, but no participation <input type="checkbox"/> Other:	Name: Relation/Agency: Role: <input type="checkbox"/> Facilitator of PCP/CFT meetings <input type="checkbox"/> Participated in @ least 1 planning meeting <input type="checkbox"/> Provided written input <input type="checkbox"/> Telephone participation <input type="checkbox"/> Invited, but no participation <input type="checkbox"/> Other:
Name: Relation/Agency: Role: <input type="checkbox"/> Facilitator of PCP/CFT meetings <input type="checkbox"/> Participated in @ least 1 planning meeting <input type="checkbox"/> Provided written input <input type="checkbox"/> Telephone participation <input type="checkbox"/> Invited, but no participation <input type="checkbox"/> Other:	Name: Relation/Agency: Role: <input type="checkbox"/> Facilitator of PCP/CFT meetings <input type="checkbox"/> Participated in @ least 1 planning meeting <input type="checkbox"/> Provided written input <input type="checkbox"/> Telephone participation <input type="checkbox"/> Invited, but no participation <input type="checkbox"/> Other:
Name: Relation/Agency: Role: <input type="checkbox"/> Facilitator of PCP/CFT meetings <input type="checkbox"/> Participated in @ least 1 planning meeting <input type="checkbox"/> Provided written input <input type="checkbox"/> Telephone participation <input type="checkbox"/> Invited, but no participation <input type="checkbox"/> Other:	Name: Relation/Agency: Role: <input type="checkbox"/> Facilitator of PCP/CFT meetings <input type="checkbox"/> Participated in @ least 1 planning meeting <input type="checkbox"/> Provided written input <input type="checkbox"/> Telephone participation <input type="checkbox"/> Invited, but no participation <input type="checkbox"/> Other:

Other individuals that I or my family would like to be part of this planning process now or in the future.

Name:

DOB:

Medicaid ID #:

Record #:

Personal Dialogue/Interview
Date(s) of Interview(s): / /

(This section must include what is important TO the person to whom this plan belongs. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) *ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.*

What has happened in my life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things I want to accomplish in the next year? What are my hopes/dreams for the future?)

Strengths: (What am I good at doing? What do people admire about me? What are my talents/gifts?)

Preferences: What is important **TO** me: (What are the people/activities/things/places that matter to me in everyday life? What don't I want in my life?)

Needs: (What would I change about my life? What is not working in my life? What do I need in order to be an active part of my community? What do I need to be healthy and safe?)

Supports: What is important **TO** me? (What do others need to know or do to support me best in relationships, in things I like to do, in work or school and ways to stay healthy and safe?)

Name:

DOB:

Medicaid ID #:

Record #:

Family/Legally Responsible Person/Informal Supports Dialogue/Interview

Date(s) of Interview(s): / /

(This section must include what is important **TO** the person and what is important **FOR** the person from the interviewee's perspective. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) *ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.*

What has happened in this person's life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things the person wants to accomplish in the next year? What are this person's hopes/dreams for the future?)

Strengths: (What is this person good at doing? What do people admire about this person? What are this person's talents/gifts?)

Preferences: What is important **TO** this person: (What are the people/activities/things/places that matter to this person in everyday life? What does the person not want in his/her life?)

Needs: (What would this person change about his/her life? What is not working in this person's life? What does this person need in order to be an active part of the community? What does he/she need to be healthy and safe?)

Supports: What is important **FOR** this person? (What do others need to know or do to support this person best in relationships, in things he/she likes to do, in work or school and ways to stay healthy and safe?)

Name:

DOB:

Medicaid ID #:

Record #:

Service/Support Providers Dialogue/Interview

Date(s) of Interview(s): / /

(This section must include what is important **TO** the person and what is important **FOR** the person from the interviewee's perspective. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) *ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.*

What has happened in this person's life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things the person wants to accomplish in the next year? What are this person's hopes/dreams for the future?)

Strengths: (What is this person good at doing? What do people admire about this person? What are this person's talents/gifts?)

Preferences: What is important **TO** this person: (What are the people/activities/things/places that matter to this person in everyday life? What does the person not want in this person's life?)

Needs: (What would this person change about his/her life? What is not working in this person's life? What does this person need in order to be an active part of the community? What does he/she need to be healthy and safe?)

Supports: What is important **FOR** this person? (What do others need to know or do to support this person best in relationships, in things he/she likes to do, in work or school and ways to stay healthy and safe?)

Name:

DOB:

Medicaid ID #:

Record #:

SUMMARY OF ASSESSMENTS/OBSERVATIONS

ASSESSMENTS COMPLETED (List the Comprehensive Clinical Assessment(s) that have been completed on the individual)	RECOMMENDATIONS FROM ALL ASSESSMENTS	LAST DATE COMPLETED	APPROXIMATE DUE DATE
		/ /	/ /
		/ /	/ /
NC TOPPS (MH/SA only) *(Not a comprehensive clinical assessment)		/ /	/ /
NC-SNAP (DD only) *(Not a comprehensive clinical assessment)		/ /	/ /

ADDITIONAL ASSESSMENTS RECOMMENDED	REASON FOR RECOMMENDATION	APPROXIMATE DUE DATE	DATE COMPLETED
		/ /	/ /
		/ /	/ /

RECOMMENDATIONS FOR SERVICES/SUPPORT/TREATMENT BASED ON ASSESSMENTS	FREQUENCY:	DURATION:	TARGET DATE:	STATE/MEDICAID/ HEALTH CHOICE
1.			/ /	
2.			/ /	
3.			/ /	

Symptoms/Observations of this Person:

- 1.
- 2.
- 3.
- 4.
- 5.

(DSM* Code)	(Diagnosis)	(Diagnosis Date)
Axis I		/ /
Axis II		/ /
Axis III		/ /
Axis IV		/ /
Axis V		/ /

Name:

DOB:

Medicaid ID #:

Record #:

ACTION PLAN

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others.)

Where am I now in relation to this outcome?

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections - “What’s important TO & FOR me”)		Support/Intervention to Reach Goal (Taken from Supports Sections)		Who will Provide Support/Intervention/ Service?	Support/Service & frequency
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal		
/ /	/ /				
/ /	/ /				
/ /	/ /				
Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued					

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections - “What’s important TO & FOR me”)		Support/Intervention to Reach Goal (Taken from Supports Sections)		Who will Provide Support/Intervention/ Service?	Support/Service & frequency
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal		
/ /	/ /				
/ /	/ /				
/ /	/ /				
Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued					

Name:

DOB:

Medicaid ID #:

Record #:

ACTION PLAN CONTINUATION

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others.)

Where am I now in relation to this outcome?

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections - “What’s important TO & FOR me”)		Support/Intervention to Reach Goal (Taken from Supports Sections)		Who will Provide Support/Intervention/ Service?	Support/Service & frequency
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal		
/ /	/ /				
/ /	/ /				
/ /	/ /				
Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued					

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections - “What’s important TO & FOR me”)		Support/Intervention to Reach Goal (Taken from Supports Sections)		Who will Provide Support/Intervention/ Service?	Support/Service
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal		
/ /	/ /				
/ /	/ /				
/ /	/ /				
Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued					

Name:

DOB:

Medicaid ID #:

Record #:

CRISIS PREVENTION/CRISIS RESPONSE

(Use this form or attach your crisis plan.)

Symptoms/behaviors that may trigger the onset of a crisis (Include lessons learned from previous crisis events):

Crisis prevention and early intervention strategies (List everything that can be done to help this person avoid a crisis):

Strategies for crisis response and stabilization (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

Specific recommendations if person arrives at the Crisis and Assessment Service:

After the crisis, identify strategies for determining what worked and what did not work, and make changes to the plan:

Name:

DOB:

Medicaid ID #:

Record #:

CRISIS PREVENTION/CRISIS RESPONSE (CONTINUATION)

Contact List (Include names as applicable, relationship and direct phone numbers or extension.)

First Responder: Telephone #: ()- - Consent/Release of Information: ☐ Yes ☐ No

Legally Responsible Person: Telephone #: ()- -

Consent/Release of Information: ☐ Yes ☐ No

(If applicable-Attach a copy of any applicable supporting legal documents)

Date of Legal Document: / /

Natural/Community Supports:

Name: Telephone #: ()- - Consent/Release of Information: ☐ Yes ☐ No

Name: Telephone #: ()- - Consent/Release of Information: ☐ Yes ☐ No

Professional Supports:

Name: Telephone #: ()- - Consent/Release of Information: ☐ Yes ☐ No

Primary Care Physician:

Telephone #: ()- - Consent/Release of Information: ☐ Yes ☐ No

Preferred Psychiatric Inpatient /Respite Provider:

Telephone #: ()- - Consent/Release of Information: ☐ Yes ☐ No

Other Professional Supports:

Name: Telephone #: ()- - Consent/Release of Information: ☐ Yes ☐ No

Name: Telephone #: ()- - Consent/Release of Information: ☐ Yes ☐ No

All Current Medications (* Update and revise list of medications anytime there is a change)	Dose:	Frequency:	Reason for Change:	Date
1.				/ /
2.				/ /
3.				/ /
4.				/ /
5.				/ /
6.				/ /
7.				/ /
8.				/ /
9.				/ /
10.				/ /

Name:

DOB:

Medicaid ID #:

Record #:

CRISIS PREVENTION/CRISIS RESPONSE (CONTINUATION)

Advanced Directives: (Advance Directives allow you to plan ahead for care in the event that there are times that you are unable to speak for yourself).

☐ Yes ☐ No I have a Living Will.

☐ Yes ☐ No I would like one.

☐ Yes ☐ No I have a Health Care Power of Attorney.

☐ Yes ☐ No I would like one.

☐ Yes ☐ No I have an Advanced Instruction for Mental Health Treatment.

☐ Yes ☐ No I would like one.

Emergency Contact or Next of Kin:

Relationship to Person:

(Address):

(Street/mailling address)

(City/State/Zip)

Home Phone: ()- -

Work Phone: ()- -

Crisis Plan Distribution List:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

COMMENTS

Comments or Concerns on Plan by the person whose plan this is and/or the legally responsible person:

Name:

DOB:

Medicaid ID #:

Record #:

Steps to address concerns:

SIGNATURES

REQUIRED for Medicaid funded services. RECOMMENDED for State funded services.

My signature below confirms that medical necessity for services requested is present, and constitutes the Service Order(s):

Signature: _____

Date: / /

(Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)

Annual review of medical necessity and re-ordering of services is due on or before: Date: / /

Person Receiving Services:

- I confirm and agree with my involvement in the development of this person-centered plan. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for my plan.

Signature: _____

Date: / /

(Required when person is his/her own legally responsible person)

- **The following signatures confirm the involvement of individuals in the development of this person-centered plan. All signatures indicate agreement with the services/supports to be provided.**
- **For state-funded services, if the first signature box on this page is not completed, the signature of *the Person Responsible for the Plan* in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.**

Legally Responsible Person Signature: _____

Date: / /

(Required, if other than the individual)

Person Responsible for the Plan Signature: _____

Date: / /

(Required)

Other Team Member Signature: _____

Date: / /

Other Team Member Signature: _____

Date: / /

Annual Review of medical necessity and re-ordering of State-funded services is due on or before: Date: / /

Name:

DOB:

Medicaid ID #:

Record #:

PLAN UPDATE/REVISION REQUESTS

Name: (Preferred Name):	DOB: / /	Medicaid ID:	Record #:
Person's Address: (Street/mailling address) (City/State/Zip)			Telephone #: (Home) () - - (Work) () - -
Type of Plan: <i>(Check the box that applies)</i> <input type="checkbox"/> Update Revision / / <input type="checkbox"/> Update Revision Including Annual Review of Medical Necessity / /		Allergies: 1. 2. 3.	

Long Range Outcome:**Where am I now in relation to this outcome?****SYMPTOM/OBSERVATION #:**

Short Range Goal (Taken from Preferences & Supports Sections - "What's important TO & FOR me")		Support/Intervention to Reach Goal (Taken from Supports Sections)	Who will Provide Support/Intervention/Service?	Support/Service
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal	
/ /	/ /			
/ /	/ /			
/ /	/ /			
Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued				

(Provide signatures on the next page)

Name:

DOB:

Medicaid ID #:

Record #:

SIGNATURES

REQUIRED for Medicaid funded services. RECOMMENDED for State funded services.

If this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, my signature below confirms that medical necessity for the service(s) requested is present and constitutes the Service Order(s):

Signature: _____

Date: / /

(Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)

Annual Review of medical necessity and re-ordering of State-funded services is due on or before: Date: / /

Person Receiving Services:

- I confirm and agree with my involvement in the development of this update/revision to my person-centered plan. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time by contacting the person responsible for my plan.

Signature: _____

Date: / /

(Required when person is his/her own legally responsible person)

- **The following signatures confirm the involvement of individuals in the development of this update/revision to the person-centered plan. All signatures indicate agreement with the services/supports to be provided.**
- **For State-Funded services, if the first signature box on this page is not completed AND this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, the signature of the *Person Responsible for the Plan* in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.**

Legally Responsible Person Signature: _____

Date: / /

(Required, if other than the individual)

Person Responsible for the Plan Signature: _____

Date: / /

(Required)

Other Team Member Signature: _____

Date: / /

Other Team Member Signature: _____

Date: / /

Annual Review of medical necessity and re-ordering of State-funded services is due on or before: Date: / /



Note: Information is fully protected as a consumer health record under HIPAA and 42 CFR, Part 2, and GS 122C and contains individually identifiable health information. Disclosure of HIPAA Protected Information between providers and other covered entities may require consumer consent. For consumers with substance abuse problems, written consent is required under 42 CFR, Part 2, for disclosure of confidential information, unless such disclosure is permitted as an exception to the General Confidentiality Rule, including a medical emergency that poses an immediate threat to health and requires immediate medical intervention. Redisclosure of SA consumer information is prohibited under 42 CFR, Part 2. Page 1 of 3: DMH/DD/SAS Rev: 08/02/06 (Electronic Form)

INSTRUCTIONS FOR PERSON-CENTERED PLAN (PCP) CONSUMER ADMISSION FORM

<p>A. <u>Consumer Name:</u> Enter consumer's First Name, Middle Initial, and Last Name: <i>up to 17 characters.</i></p> <p>B. <u>Consumer DOB:</u> Enter consumer's date of birth, by month, day, and year: <i>8 characters.</i></p> <p>C. <u>Provider Consumer Record No:</u> Enter provider's consumer record number: <i>up to 10 characters.</i></p> <p>D. <u>LME Facility Code:</u> LME Facility Code may be completed as indicated by LME, or may be assigned by LME upon receipt of Form: <i>5 characters.</i></p> <p>E. <u>LME Consumer Record No:</u> LME Consumer Record Number may be completed as indicated by LME, or may be assigned by the LME upon receipt of Form: <i>10 characters.</i></p> <p>1. <u>Name of LME responsible for receiving this Consumer's PCP:</u> Enter the name of the LME responsible for receiving this consumer's PCP: <i>up to 24 characters.</i></p> <p>2. <u>Consumer Current Admission Date:</u> Enter month, day, and year which represents the date that this consumer was admitted to a facility for the current episode of care: <i>8 characters.</i></p> <p>3. <u>Consumer Co. of Residence:</u> Enter a county name (<i>up to 12 characters</i>) or valid county code (<i>3 characters</i>) for the state of North Carolina as listed in the CDW Data Dictionary.</p> <p>4. <u>Consumer's Residence Zip Code:</u> Indicate the consumer's residential zip code: <i>9 characters.</i></p> <p>5. <u>Ethnicity:</u> Indicate the consumer's Hispanic origin: (✓ <i>One</i>).</p> <p>6. <u>Marital Status at the time of admission:</u> Indicate the consumer's marital status at time of the current admission: (✓ <i>One</i>).</p> <p>7. <u>Race:</u> Indicate the consumer's primary racial affiliation: (✓ <i>One</i>).</p> <p>8. <u>Gender:</u> Indicate the consumer's sex: (✓ <i>One</i>).</p> <p>9. <u>Veteran Status:</u> Indicate whether the individual has served on active duty in the armed forces of the U.S., including the Coast Guard: (✓ <i>One</i>).</p> <p>10. <u>Education Level:</u> Enter the appropriate Education Level code from CDW list below for highest grade/degree completed by the consumer at time of the current admission: <i>2 characters.</i></p> <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 50%;">00= None, never attended school</td> <td style="width: 50%;">01= First grade</td> </tr> <tr> <td>02= Second grade</td> <td>03= Third grade</td> </tr> <tr> <td>04= Fourth grade</td> <td>05= Fifth grade</td> </tr> <tr> <td>06= Sixth grade</td> <td>07= Seventh grade</td> </tr> <tr> <td>08= Eighth grade</td> <td>09= Ninth grade</td> </tr> <tr> <td>10= Tenth grade</td> <td>11= Eleventh grade</td> </tr> <tr> <td>12= Twelfth grade/high school graduate</td> <td>14= Some college</td> </tr> <tr> <td>16= Baccalaureate degree</td> <td>17= Post graduate school (after MA/MS)</td> </tr> <tr> <td>18= Post bachelor's degree</td> <td></td> </tr> </table>	00= None, never attended school	01= First grade	02= Second grade	03= Third grade	04= Fourth grade	05= Fifth grade	06= Sixth grade	07= Seventh grade	08= Eighth grade	09= Ninth grade	10= Tenth grade	11= Eleventh grade	12= Twelfth grade/high school graduate	14= Some college	16= Baccalaureate degree	17= Post graduate school (after MA/MS)	18= Post bachelor's degree		<table style="width: 100%; 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INSTRUCTIONS FOR PERSON-CENTERED PLAN (PCP) CONSUMER ADMISSION FORM

- 14. English Proficiency:** Indicate whether English is spoken and understood by the consumer at a relatively high level of proficiency, e.g. no interpreter is required: (✓ One).
- 15. Primary Language:** Indicate the language spoken and/or understood by the consumer: (✓ One).
- 16. Pregnancy Status:** Indicate whether the consumer is pregnant at the time of the current admission: (✓ One).
- 17. Diagnosis(es) Effective Date:** Enter the date by month, day, and year that the consumer is formally admitted to a program for treatment of the specified ICD-9 diagnosis code(s) described in this form or is assessed with this diagnosis: **8 characters.**
- 18. Diagnosis Code(s) (ICD-9):** Enter up to three ICD-9 codes describing, in order of importance, the condition(s) established after screening and assessment, to be chiefly responsible for occasioning this admission of a consumer: **5 characters.**
- 19. Date Started Substance Abuse Treatment:** Enter date by month, day, and year for first substance abuse treatment in the current admission: **8 characters.**
- 20a. Substance(s) Abused:** Enter the appropriate Substance Abuse code from the CDW list below for Primary, Secondary, and Additional Substance Abused by the consumer in the 30 days prior to the current admission: **2 characters.**
- | | |
|-----|---|
| 00= | None (e.g. client in remission) |
| 01= | Alcohol |
| 02= | Cocaine/Crack |
| 03= | Marijuana/Hashish (Cannibus) |
| 04= | Heroin |
| 05= | Non-Prescription Methadone |
| 06= | Other Opiates and Synthetics (Morphine, codeine, Dilaudid, Percodan) |
| 07= | PCP (Phencyclidine) |
| 08= | Other Hallucinogens (LSD, MDA, Psilocybin, Mescaline) |
| 09= | Methamphetamine (Ice) |
| 10= | Other Amphetamines (Dextroamphetamine, Dexedrine, Amphetamine, Crank, Speed) |
| 11= | Other Stimulants (e.g. caffeine) |
| 12= | Benzodiazepine (Valium, Librium, Tranxene) |
| 13= | Other Tranquilizers (Thorazine, Haldol) |
| 14= | Barbiturates (Phenobarbital, Secobarbital, Pentobarbital) |
| 15= | Other Sedatives and Hypnotics (Doriden, Quaalude) |
| 16= | Inhalants (Nitrites, Freon, glue, turpentine, paint thinner, rubbing alcohol) |
| 17= | Over the counter drugs (e.g. diet tablets, cough syrup) |
| 18= | Other |
| 19= | Tobacco |

- 20c. Frequency of Use:** Enter the appropriate code from the CDW list below for Primary, Secondary, and Additional Substance Abused by the consumer in the 30 days prior to the current admission episode: **1 character.**
- | | |
|---------------------------------------|--|
| 0= Not used in past month | 1= Used one to three times in past month |
| 2= Used one to two times in past week | 3= Used three to six times in past week |
| 4= Used daily in past week | 9= Unknown |
- 20d. Usual Route of Administration:** Enter the appropriate Usual Route of Administration code from the CDW list below for Primary, Secondary, and Additional Substance Abused by the consumer in the 30 days prior to the current admission: **1 character.**
- | | | |
|--------------|------------|---------------|
| 1= Oral | 2= Smoking | 3= Inhalation |
| 4= Injection | 5= Other | 9= Unknown |
- Complete consumer identifying numbers below (as applicable and available):*
- 21. Consumer Unique Identifier:** Enter consumer number: **10 or 11 characters.** The unique identifier consists of the first three characters of last name, 1st character of first name, 6 character birth date, and an identifier if more than one LME consumer has the same unique identifier number.
- 22. Consumer Social Security Number:** Enter consumer number: **9 characters.** This number is needed for cross-referencing with the Department's Common Name Database Services (CNDS). A consumer SSN will not always be available to a provider when completing this Form.
- 23. Consumer Medicaid Number:** Enter consumer number: **10 characters.**
- Complete provider identifying information below (as applicable and available):*
- 24. Name of Provider Agency:** Enter name of provider agency: **up to 24 characters.**
- 25. Medicaid Provider Enrollment No:** Enter provider number: **8 characters.**
- 26. IPRS Attending Provider No:** Enter provider number: **8 characters.**
- 27. National Provider Identifier (NPI) No:** Enter provider number: **10 characters.**
- 28. First and Last Name of Provider Staff submitting this Form to LME:** Enter first and last name of staff submitting this form to LME: **up to 24 characters.**
- 29. E-Mail of Provider Staff submitting this Form to LME:** Enter e-mail address of provider staff submitting this form to LME: **up to 24 characters.**
- 30. Area Code and Phone No. of Provider:** Enter area code and phone number of provider staff submitting this form to the LME: **10 characters.**
- 31. Date Form Submitted to LME:** Enter date by month, day, and year that this form was submitted to the LME by the provider: **8 characters.**

NAME: _____ RECORD #: _____

's Plan

Plan Meeting Date: _____

For Plan Approver Only

Plan Approved By: _____

Plan Approved Date: ____ / ____ / ____

Name (As appears on Medicaid Card)	Preferred Name
LME	Case Manager
Agency/Provider Name:	
Record Number	Date of Birth
Address	Phone
City, State, Zip	Medicaid County
Social Security Number	Medicaid ID#:
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Medicare/Insurance
Race/Ethnicity: White__ African Am__ Hispanic__ Native Am__ Asian__ Other__	

TYPE <input type="checkbox"/> Initial Plan of Care <input type="checkbox"/> CNR	RESIDENCY <input type="checkbox"/> Private home with natural family <input type="checkbox"/> Individual Residence <input type="checkbox"/> Supervised Living ____ # of consumers <input type="checkbox"/> Group Home ____ # of consumers <input type="checkbox"/> Child Foster Care <input type="checkbox"/> AFL /Therapeutic Home <input type="checkbox"/> Other (Specify) _____
CAP-MR/DD <input type="checkbox"/> At Risk for ICF/MR Placement <input type="checkbox"/> Previously in an ICF-MR bed	<input type="checkbox"/> NC-SNAP Score _____

CONTACT PERSON
<input type="checkbox"/> Next of Kin/ Relationship
<input type="checkbox"/> Legally Responsible Person
Type:
Date of Action:
Name:
Address:
City/State/Zip:
Phone (home):
Phone (work):

PARTICIPANTS IN PLAN DEVELOPMENT

Medical Information

Date Completed _____

	CODE	DIAGNOSIS	Indicate Primary Diagnosis with
AXIS I	_____	_____	_____
	_____	_____	_____
AXIS II	_____	_____	_____
	_____	_____	_____
AXIS III	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
AXIS IV	_____	_____	_____
	_____	_____	_____
AXIS V	_____	_____	_____

MEDICATION	TARGET SYMPTOMS of THIS PERSON (Inc. Frequency, Intensity, Specificity)

ASSESSMENTS (Including Medical and Dental)	LAST DATE	APPROX. DUE DATE

NAME: _____ RECORD #: _____

What has happened in _____ life this past year (or if new plan, within the last few years)?
What goals have been met?

What does _____ want his/her life to be like? What is important? What are his/her goals?

NAME: _____ RECORD #: _____

Who am I? What is important to me? What are my strengths and preferences?

What would I change about my life? What are problems or needs that I may have? What is not working in my life?

What will we accomplish with this plan?

NAME: _____ RECORD #: _____

What support do I need to maintain what is important to me in my life, and to change the things noted above in my life?

What natural supports are available to me? Family, friends, co-workers, etc.?

What community supports are available to me? Church, community organizations, civic groups?

In addition to the above, what other supports may I need including public funded supports?

Are there needs in my life related to health and safety, such as identified medical issues, need for behavior or crisis plan? If so, how will they be addressed?

What is the process for obtaining back-up staff in case of emergency?

NAME: _____

RECORD #: _____

Action Plan

This action plan is developed to help _____ meet his/her goals through addressing what needs to change and needs to be maintained as identified on the previous pages.

	DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #
METHOD OF EVALUATION:	

WHAT	How	WHO'S RESPONSIBLE	BY WHEN	SERVICE AND FREQUENCY

	DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #
METHOD OF EVALUATION:	

WHAT	How	WHO'S RESPONSIBLE	BY WHEN	SERVICE AND FREQUENCY

(Repeat page as necessary)

NAME: _____

RECORD #: _____

Case Management/Service Monitoring Plan

TYPE	FREQUENCY / CONTACT SCHEDULE
Face to Face: <div style="text-align: right; padding-right: 20px;">Individual</div> <div style="text-align: right; padding-right: 20px;">Family / Guardian</div> <div style="text-align: right; padding-right: 20px;">Provider(s)</div>	
Collaterals: <div style="text-align: right; padding-right: 20px;">Individual</div> <div style="text-align: right; padding-right: 20px;">Family / Guardian</div> <div style="text-align: right; padding-right: 20px;">Provider(s)</div> <div style="text-align: right; padding-right: 20px;">Education</div> <div style="text-align: right; padding-right: 20px;">Others (residential/ vocational, etc.)</div>	
<div style="text-align: right; padding-right: 20px;">Service Observations / Visits</div> <div style="text-align: right; padding-right: 20px;">Review of Service Documentation</div> <div style="text-align: right; padding-right: 20px;">Review of Outcomes/Supports Strategies</div> <div style="text-align: right; padding-right: 20px;">Review of CM Indicator on Medicaid Card</div>	
Other / Comments	

Attached are the following documents (check all that apply):

- | | | |
|--|--------------------------|--|
| NC-SNAP (required for new and renewal) | <input type="checkbox"/> | |
| Crisis Plan | <input type="checkbox"/> | |
| Behavior Plan | <input type="checkbox"/> | |
| Advanced Health/Mental Health Directive/DNR/PA | <input type="checkbox"/> | |
| Justification for Equipment or Supplies | <input type="checkbox"/> | |
| Individual Education Plan (IEP) | <input type="checkbox"/> | |
| Other (Explain) | <input type="checkbox"/> | |

Signatures

The following signatures confirm the involvement of individuals in the development of this assessment and plan of care. All signatures indicate concurrence with the services/supports to be provided.

- 1) I confirm/concur my involvement in the development of this assessment and plan of care. My signatures indicate concurrence with the services/supports to be provided.
- 2) I understand that I have the choice of seeking care in an intermediate care facility for the mentally retarded instead of participating in the Community Alternatives Program for the Mentally Retarded / Developmentally Disabled (CAP/MR-DD). I choose to participate in CAP/MR-DD.
- 3) I understand that I have the choice of service providers and case managers and may change at anytime by contacting my case manager.

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Case Manager: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

NAME: _____ RECORD #: _____

Plan Update/Revision

Implementation Date: _____

What has happened in _____'s life (personal or clinical) to cause the need for revision?
(Attach update NC-SNAP if there are changes)

Based on what is happening in my life, what is important to me now? What are my strengths and preferences?

Based on what is happening in my life, what needs to change now? What new problems or needs do I have? What is not working in my life?

What do we need to know or do to support _____ differently?

_____ DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME # _____

WHAT	How	WHO'S RESPONSIBLE	BY WHEN	SERVICE & FREQUENCY

Required Signatures: The following confirms the involvement of the individual / guardian in the update of this plan including revision to the cost summary.

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Case Manager: _____ Date: _____

_____ Date: _____

CAP-MR/DD Cost Summary

10/1/2007

(1) Consumer Name:

(2) Medicaid ID: _____

(3) Consumer Record Number:

(4) Effective Date:

(5) Revision Effective Date:

(6) LME Name:

(7) SNAP Index Score:

(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
Service/Equipment	Service Code	Provider Agency	Units a Month	Unit Interval	FROM Date	TO Date	Established Rate	Max. Monthly Authorization	Annual CAP-MR Author.
(18) TOTAL MONTHLY AND ANNUAL AUTHORIZED CAP-MRDD WAIVER LIMITS									

Annual Authorization Limits Within LME Approved Authority

(19) Comments:

APPENDIX B

Core Rules Self Study – Client Records Checklist

Name of Agency:
Date of Self Study Completed:
Date of on-site review if applicable:

CLIENT RECORDS CHECKLIST

The following information is required in client records.

Records may be reviewed on-site.

Service: Client : _____		LME USE ONLY				
		Met	Not Met	NA	Check if on-site review is needed	Comments
1.	Client Face Sheet [27G.0206(a)(1)]					
2.	Emergency Information [27G.0206(a)(5)]					
3.	Consent for Treatment [27D.0303(d)]					
4.	Consent for planned use of a restrictive intervention (not to exceed 6 mo)[27D.0303(b)]					
5.	Consent to seek emergency care from hospital or physician [27G.0206(a)(6)].					
6.	Consent to Release Information, if applic. (26B .0202 & .0203)					
7.	Disclosure of Confidential Info Form A64(26B .0301)					
8.	State required forms are utilized, to include CAP-MR/DD Plan of Care and cost summary, DHHS Restrictive Intervention Details Report & DHHS Incident & Death Report.					
9.	Explanation of Client Rights (27D.0201)					
10.	If applicable, physical disorders dx. ICD-9-CM					
11.	Screening [27G.0201(a)(6)]					
12.	Assessed presenting problem/need [27G.0201(a)(6)(A)]					
13.	Assessed agency ability to meet needs [27G.0201(a)(6)(B)]					
14.	Disposition (referrals & recommendations) [27G.0201(a)(6)(C)]					
15.	Service Order					
16.	Present for type services					
17.	Pre-dates services					
18.	Signed by authorized person					

19.	Assessment: [27G.0205(a)]					
20.	Completed according to policy, prior to delivery of services [27G.0205(a)]					
21.	Reason for admission: presenting problem [27G.0205(a)(1)]					
22.	Strengths described [27G.0205(a)(2)]					
23.	Preferences					
24.	Diagnosis according to DSM-IV-TR [27G.0206(a)(2)]					
25.	Social/family/medical history [27G.0205(a)(4)]					
26.	Evaluations present [27G.0205(a)(5)]					
27.	Mental status, as appropriate					
28.	Other eval.or doc. used to meet elements are referenced and doc. to note review and that info is current & accurate.					
29.	Assessment is reviewed & updated as appropriate					
30.	Service Plan: [27G .0205(c)]					
31.	Began at admission (Must be prior to delivery of services)					
32.	Updated/revised to reflect needs or changes					
33.	Based on assessment of needs/problems with capabilities, interests, preferences, aspirations, & tx. & personal supports. [27G .0205(c)]					
34.	Developed with client/responsible person within 30 days if expected to receive services beyond 30 days. [27G .0205(c)]					
35.	Includes: [27G .0205(d)]					
36.	- service goals/outcomes & projected date of achievement [27G .0205(d)(1)]					
37.	- specific modalities/interventions/strategies with frequency & duration [27G .0205(d)(2)]					
38.	- responsibilities of team members [27G .0205(d)(3)]					
39.	- target date for review of goals, modalities, frequency, etc., with client or responsible person that does not exceed 12 months [27G .0205(d)(4)]					
40.	- basis for evaluation or assessment of outcome achievement [27G .0205(d)(5)]					
41.	- signature of staff & consumer/legally responsible person (or statement of why not) (Minor receiving mh or sa services have exceptions) [27G .0205(d)(6)]					

42.	CAP-MR/DD has plan of care and cost summary from CAP manual.					
43.	If services delivered prior to establishment of plan, documentation of strategies used. [27G .0205(b)]					
44.	Include planned restrictive intervention & approvals [27E.0104(f)]					
45.	Restriction of Rights documented					
46.	Review/Revision of Service Plan					
47.	Doc. of review by resp. prof. by target dates, when needs change, or service provider changes.					
48.	Review of goals, modalities/intervention, frequency & duration					
49.	Staff's dated signature & consumer/legally responsible person's dated signature for consent/agreement to plan or why not obtained. (even if no changes)					
50.	CAP has a new plan annually during the consumers' birthday month.					
51.	Psychosocial Plan review every six months					
52.	Progress Notes					
53.	Full date service provided (mo/day/yr)					
54.	Duration of service for periodic & day/night					
55.	Purpose of contact as it relates to goal					
56.	description of intervention/activity					
57.	Assessment of progress towards goals/outcomes					
58.	Professionals signature & credentials, degree, or license who provided service					
59.	Paraprofessionals signature & position who provided service.					
60.	Periodic service note at least daily per service					
61.	CAP services this applies to are: Crisis Stabilization, Family Training & Therapeutic Case Consultation.					
62.	Date of service, duration of service, task performed, signature documented daily to reflect service provided for Personal Assistance, MR Personal Care, In-Home Aide, Interpreter, CAP respite. Non-CAP respite has hourly-per date of service Y community per					
63.	Documentation of service is within 24 working hours					
64.	Incidents					
65.	Record the description of event, action taken on behalf of client and client's conditions following the event.(27G .0603)					

66.	Use of planned interventions [27E.0104(g)]					
67.	Use of protective devices documented [27E.0105(a)]					
68.	Incident report filed separately from record					
69.	Medication: (27G.0209)					
70.	Written order for prescription and non prescription drugs by person authorized by law to prescribe drugs. [27G.0209(a)(1)]					
71.	Written order for self administration [27G.0209(c)(2)]					
72.	Refusal of medication documented [27G.0209(h)]					
73.	Psychotropic drugs reviewed by physician or pharmacist every six months & recorded. [27G.0209(f)(1)]					
74.	Medication Administration Record (MAR) [27G.0209(c)(4)]					
75.	Consumer's name [27G.0209(c)(4)(A)]					
76.	Name, strength, quantity of drug [27G.0209(c)(4)(B)]					
77.	Instructions for administration [27G.0209(c)(4)(C)]					
78.	Date and time drug administered [27G.0209(c)(4)(D)]					
79.	Name or initials of person administering meds. [27G.0209(c)(4)(E)]					
80.	Medications Errors [27G.0209(h)]					
81.	Drug administration error and significant adverse reactions reported immediately to physician or pharmacist. Drug administration and drug reaction shall be properly recorded in drug record. [27G.0209(h)]					
82.	Orders & copies of lab tests					
83.	Case Management Service Notes					
84.	Date of service					
85.	Type of activity					
86.	Location where service provided					
87.	Brief description of activity & outcome					
88.	Total time (duration)					
89.	Signature & credentials, degree or licensure of case manager					
90.	Service Authorization/Utilization Reviews					

APPENDIX C

MH/DD/SA Service Delivery Table

MH/DD/SA Service Delivery Table

Entries in italics indicate basic services.

Procedure Code:	Service Description:	Billing Unit:	Type of Service:	Minimum Frequency of Service Documentation:	Service Order?	Covered by Medicaid?
YP620	Adult Developmental Vocational Program [ADVP]	Each 15 Minutes	Day/Night	Quarterly	N	N
YP830	<i>Alcohol and/or Drug Assessment – Non-Licensed Provider</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>N</i>	<i>N</i>
H0005	<i>Alcohol and/or Drug Services; Group Counseling by Clinician</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y After 8/26 visits</i>	<i>Y</i>
YP835	<i>Alcohol and/or Drug Services; Group Counseling by Non-Licensed Provider</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y</i>	<i>N</i>
H0014	Ambulatory Detoxification	Each 15 Minutes	24-Hour	Daily	Y	Y
H0040	Assertive Community Treatment Team [ACTT]	4-Contact Threshold	Periodic	Daily	Y	Y
YP230	Assertive Outreach	Each 15 Minutes	Periodic	Daily	N	N
H0001	<i>Behavioral Health Assessment</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>N</i>	<i>Y</i>
H0004	<i>Behavioral Health Counseling and Therapy</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y After 8/26 visits</i>	<i>Y</i>
YP831	<i>Behavioral Health Counseling – Non-Licensed Provider</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y</i>	<i>N</i>
YP832	<i>Behavioral Health Counseling – Group Therapy – Non-Licensed Provider</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y</i>	<i>N</i>
YP833	<i>Behavioral Health Counseling – Family Therapy with Client – Non-Licensed Provider</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y</i>	<i>N</i>
YP834	<i>Behavioral Health Counseling – Family Therapy without Client – Non-Licensed Provider</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y</i>	<i>N</i>
H0004HQ	<i>Behavioral Health Counseling Outpatient Treatment – Group</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y After 8/26 visits</i>	<i>Y</i>
H0004HR	<i>Behavioral Health Counseling Outpatient Treatment - Family Therapy With Client</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y After 8/26 visits</i>	<i>Y</i>
H0004HS	<i>Behavioral Health Counseling Outpatient Treatment - Family Therapy Without Client</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>Y After 8/26 visits</i>	<i>Y</i>
H2012HA	Child and Adolescent Day Treatment	Per Hour	Day/Night	Daily	Y	Y
YP650	Community Rehabilitation Program [Sheltered Workshop]	Each 15 Minutes	Day/Night	Quarterly	N QP/AP must certify eligibility	N
YA213	Community Respite [CMSED]	Per Day	24-Hour	Daily	N	N
YP730	Community Respite	Per Day	24-Hour	Daily	N	N

Procedure Code:	Service Description:	Billing Unit:	Type of Service:	Minimum Frequency of Service Documentation:	Service Order?	Covered by Medicaid?
H0036HB	Community Support: Adults – Individual	Each 15 Minutes	Periodic	Per Event	Y	Y
H0036HQ	Community Support: Adults – Group	Each 15 Minutes	Periodic	Per Event	Y	Y
H0036HA	Community Support: Children/Adolescents - Individual	Each 15 Minutes	Periodic	Per Event	Y	Y
H0036HQ	Community Support: Children/Adolescents - Group	Each 15 Minutes	Periodic	Per Event	Y	Y
H2015HT	Community Support Team [CST]	Each 15 Minutes	Periodic	Daily	Y	Y
YM580	Day Supports	Per Day	Periodic	Daily	N	N
YP660	Day/Evening Activity	Each 15 Minutes	Day/Night	Quarterly	N	N
YP610	Developmental Day	Each 15 Minutes	Day/Night	Quarterly	N	N
H2014	Developmental Therapy - Professional – Individual	Each 15 Minutes	Periodic	Daily	Y	N
H2014HQ	Developmental Therapy - Professional – Group	Each 15 Minutes	Periodic	Daily	Y	N
H2014HM	Developmental Therapy - Paraprofessional - Individual	Each 15 Minutes	Periodic	Daily	Y	N
H2014U1	Developmental Therapy - Paraprofessional – Group	Each 15 Minutes	Periodic	Daily	Y	N
T1023	Diagnostic Assessment	Per Day	Periodic	Per Event	N	Y
YP690	Drop-In Center – Attendance	Each 15 Minutes	Day/Night	Daily [recommended]	N	N
YP692	Drop-In Center – Coverage Hours	Each 15 Minutes	Day/Night	Daily [recommended]	N	N
YP485	Facility Based Crisis Program – Non-Medicaid	Per Hour	24-Hour	Per Shift	Y	N
YM755	Family Living – High	Per Day	24-Hour	Monthly	N	N
YP740	Family Living – Low	Per Day	24-Hour	Monthly	N	N
YP750	Family Living – Moderate	Per Day	24-Hour	Monthly	N	N
YM600	Financial Support Services	Each 15 Minutes	Periodic	Daily	N	N
YP780	Group Living – High	Per Day	24-Hour	Monthly	N	N
YP760	Group Living – Low	Per Day	24-Hour	Monthly	N	N
YP770	Group Living – Moderate	Per Day	24-Hour	Monthly	N	N
YM686	Guardianship	Per Month	Monthly	Monthly	N	N
YA125	Hourly Respite [CMSRD]	Each 15 Minutes	Periodic	Daily	N	N
YP011	Hourly Respite – Group	Each 15 Minutes	Periodic	Daily	N	N
YP010	Hourly Respite – Individual	Each 15 Minutes	Periodic	Daily	N	N
YM700	Independent Living – MR/MI	Per Day	NA	NA	N	N

Procedure Code:	Service Description:	Billing Unit:	Type of Service:	Minimum Frequency of Service Documentation:	Service Order?	Covered by Medicaid?
YM716	Individual Supports	Per Month	Monthly	Monthly	N	N
YP820	Inpatient Hospitalization	Per Day	24-Hour	Per Shift	Y	N
H2022	Intensive In-Home Services	Per Day	Periodic	Daily	Y	Y
YM645	Long Term Vocational Support	Each 15 Minutes	Day/Night	Quarterly	N	N
H2036	Medically Supervised or ADATC Detoxification/Crisis Stabilization	Per Day	24-Hour	Daily	Y	Y
H0031	<i>Mental Health Assessment</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>N</i>	<i>Y</i>
YP836	<i>Mental Health Assessment – Non-Licensed Provider</i>	<i>Each 15 Minutes</i>	<i>Periodic</i>	<i>Per Event</i>	<i>N</i>	<i>N</i>
H2011	Mobile Crisis Management	Each 15 Minutes	Periodic	Daily	Y	Y
H2033	Multisystemic Therapy	Each 15 Minutes	Periodic	Daily	Y	Y
H0010	Non-Hospital Medical Detoxification	Per Day	24-Hour	Daily	Y	Y
H0020	Opioid Treatment	Per Event	Periodic	Per Event	Y	Y
H0035	Partial Hospitalization – Children and Adults	Each 15 Minutes	Day/Night	Daily, or must meet Medicare requirements if billing Medicare	Y	Y
YP020	Personal Assistance – Individual	Each 15 Minutes	Periodic	Daily	N	N
YM050	Personal Care Services	Each 15 Minutes	Periodic	Daily	N	N
S9484	Professional Treatment Services In Facility-Based Crisis Program	Per Hour	24-Hour	Per Shift	Y	Y
YA230	Psychiatric Residential Treatment Facility [PRTF]	Per Day	24-Hour	Per Shift	Y	Y
H2017	Psychosocial Rehabilitation [PSR]	Each 15 Minutes	Day/Night	Daily	Y	Y
YM850	Residential Supports	Per Day	Periodic	Daily	N	N
S5145	Residential Treatment - Level II - Family Type	Per Day	24-Hour	Daily	Y	Y
H2020	Residential Treatment - Level II – Program Type	Per Day	24-Hour	Per Shift	Y	Y
H0019	Residential Treatment - Levels III - IV [Behavioral Health – Long Term Residential]	Per Day	24-Hour	Per Shift	Y	Y
YA234	Room and Board – Level II [Age 5 or Less]	Per Day	NA	NA	N	N
YA235	Room and Board – Level II [Age 6-12]	Per Day	NA	NA	N	N
YA236	Room and Board – Level II [Age 13+]	Per Day	NA	NA	N	N
YA232	Room and Board – Level III [1-4 Beds]	Per Day	NA	NA	N	N

Procedure Code:	Service Description:	Billing Unit:	Type of Service:	Minimum Frequency of Service Documentation:	Service Order?	Covered by Medicaid?
YA233	Room and Board – Level III [5+ Beds]	Per Day	NA	NA	N	N
YA237	Room and Board – Level IV [1-4 Beds]	Per Day	NA	NA	N	N
YA238	Room and Board – Level IV [5+ Beds]	Per Day	NA	NA	N	N
YP790	Social Setting Detoxification	Per Day	24-Hour	Per Shift	Y	N
H2035	Substance Abuse Comprehensive Outpatient Treatment [SACOT]	Per Hour	Periodic	Daily	Y	Y
H2034	Substance Abuse Halfway House	Per Day	24-Hour	Daily	Y	N
H0015	Substance Abuse Intensive Outpatient Program [SAIOP]	Per Day	Day/Night	Daily	Y	Y
H0013	Substance Abuse Medically Monitored Community Residential Treatment	Per Day	24-Hour	Per Shift	Y	Y
H0012HB	Substance Abuse Non-Medical Community Residential Treatment – Adult	Per Day	24-Hour	Per Shift	Y	Y
YM725	Supervised Living – High	Per Day	24-Hour	Monthly	N	N
YP710	Supervised Living – Low	Per Day	Client Bed Day	Monthly	N	N
YP720	Supervised Living – Moderate	Per Day	24-Hour	Monthly	Only if live-in employed	N
YM811	Supervised Living – MR/MI - 1 Resident	Per Day	Daily	Monthly	N	N
YM812	Supervised Living – MR/MI - 2 Residents	Per Day	Daily	Monthly	N	N
YM813	Supervised Living – MR/MI - 3 Residents	Per Day	Daily	Monthly	N	N
YM814	Supervised Living – MR/MI - 4 Residents	Per Day	Daily	Monthly	N	N
YM815	Supervised Living – MR/MI - 5 Residents	Per Day	Daily	Monthly	N	N
YM816	Supervised Living – MR/MI - 6 Residents	Per Day	Daily	Monthly	N	N
YP640	Supported Employment – Group	Per Day	Day/Night	Quarterly	N	N
YP630	Supported Employment – Individual	Per Day	Day/Night	Quarterly	N	N
T1017HI	Targeted Case Management [TCM]	Each 15 Minutes	Periodic	Per Event	Y	Y

Procedure Code:	Service Description:	Billing Unit:	Type of Service:	Minimum Frequency of Service Documentation:	Service Order?	Covered by Medicaid?
YA255	Therapeutic Leave - Residential Level II - Therapeutic Foster Care	Per Day	24-Hour	Per Event	N	N
YA254	Therapeutic Leave - Residential Level II - Program Type	Per Day	24-Hour	Per Event	N	N
YA256	Therapeutic Leave - Residential Level III [1-4 Beds]	Per Day	24-Hour	Per Event	N	N
YA257	Therapeutic Leave - Residential Level III [5+ Beds]	Per Day	24-Hour	Per Event	N	N
YA258	Therapeutic Leave - Residential Level IV [1-4 Beds]	Per Day	24-Hour	Per Event	N	N
YA259	Therapeutic Leave - Residential Level IV [5+ Beds]	Per Day	24-Hour	Per Event	N	N
YA265	Therapeutic Leave Room and Board - Level II - [Age 5 or less]	Per Day	NA	NA	N	N
YA266	Therapeutic Leave Room and Board - Level II - [Age 6-12]	Per Day	NA	NA	N	N
YA267	Therapeutic Leave Room and Board - Level II - [Age 13+]	Per Day	NA	NA	N	N
YA263	Therapeutic Leave Room and Board - Level III - [1-4 Beds]	Per Day	NA	NA	N	N
YA264	Therapeutic Leave Room and Board - Level III - [5+ Beds]	Per Day	NA	NA	N	N
YA268	Therapeutic Leave Room and Board - Level IV - [1-4 Beds]	Per Day	NA	NA	N	N
YA269	Therapeutic Leave Room and Board - Level IV - [5+ Beds]	Per Day	NA	NA	N	N
YA241	Wilderness Camp	Per Day	24-Hour	Daily	N	N

CAP-MR/DD Procedure Codes:	Service Description:	Billing Unit:	Type of Service:	Minimum Frequency of Service Documentation:	Service Order?	Covered by Medicaid?
S5102	Adult Day Health Care Services	Per Day	Day/Night	Daily	Y	Y
T2028	Augmentative Communication – Purchases	NA	NA	Per Event	Y	Y
V5336	Augmentative Communication – Repairs	NA	NA	Per Event	Y	Y
H2011	Crisis Services	Each 15 Minutes	Periodic	Per Event	Y	Y
T2021HQ	Day Support – Group – 2 or More Clients,	Each 15 Minutes	Periodic	Daily	Y	Y
T2021	Day Support – Individual	Each 15 Minutes	Periodic	Daily	Y	Y
T1019	Enhanced Personal Care	Each 15 Minutes	Periodic	Daily	Y	Y
T1005	Enhanced Respite Care	Each 15 Minutes	Periodic	Daily	Y	Y
H2015HQ	Home and Community Support – Group of 2 or More Clients	Each 15 Minutes	Periodic	Daily	Y	Y
H2015	Home and Community Support – Individual	Each 15 Minutes	Periodic	Daily	Y	Y
S5165	Home Modifications	NA	NA	Per Event	Y	Y
S5110	Individual Caregiver Training and Education	Each 15 Minutes	Periodic	Daily	Y	Y
S5161	Personal Emergency Response System	Per Month	NA	Per Event	Y	Y
S5125	Personal Care Services	Each 15 Minutes	Periodic	Daily	Y	Y
H2016	Residential Support – Level 1	Per Day	Day/Night	Daily	Y	Y
T2014	Residential Support – Level 2	Per Day	Day/Night	Daily	Y	Y
T2020	Residential Support – Level 3	Per Day	Day/Night	Daily	Y	Y
H2016HI	Residential Support – Level 4	Per Day	Day/Night	Daily	Y	Y

CAP-MR/DD Procedure Codes:	Service Description:	Billing Unit:	Type of Service:	Minimum Frequency of Service Documentation:	Service Order?	Covered by Medicaid?
H0045	Respite Care – Institutional	Per Day	24-Hour	State MR Center documentation requirements	Y	Y
T1005TE	Respite Care – Nursing – LPN	Each 15 Minutes	Periodic	Daily	Y	Y
T1005TD	Respite Care – Nursing – RN	Each 15 Minutes	Periodic	Daily	Y	Y
S5150HQ	Respite – Non Institutional Nursing – Group [2-3 Clients]	Each 15 Minutes	Periodic	Daily	Y	Y
S5150	Respite – Non Institutional – Individual	Each 15 Minutes	Periodic	Daily	Y	Y
T2025	Specialized Consultative Services	Each 15 Minutes	Periodic	Daily	Y	Y
T1999	Specialized Equipment and Supplies	NA	NA	Per Event	Y	Y
H2025HQ	Supported Employment – Group	Each 15 Minutes	Day/Night	Quarterly	Y	Y
H2025	Supported Employment – Individual	Each 15 Minutes	Day/Night	Quarterly	Y	Y
T2001	Transportation	NA	NA	Per Event	Y	Y
T2039	Vehicle Adaptations	NA	NA	Per Event	Y	Y

For more information about service codes and target populations, see IPRS Service Array:
<http://www.dhhs.state.nc.us/mhddsas/iprsmenu/arrayofservices-0607-master-20061127.xls>

APPENDIX D

Sample Forms

Instructions for Using the Sample Grid

Sample Grid Form

Sample Service Note A

Sample Service Note B

Sample Service Note C

Sample Service Note D

Sample Form for PSR Daily Note

CAP-MR/DD Residential Support Grid

Appendix D

INSTRUCTIONS FOR USING THE SAMPLE GRID

The use of grids is applicable to the following services only:

- Behavioral Health Prevention Education Services in Selective and Indicated Populations
- Day Supports [CAP-MR/DD]
- Home and Community Supports [CAP-MR/DD]
- Personal Care [CAP-MR/DD], unless provided by a home care agency that is following home care licensure rules. Note: When Personal Care [CAP-MR/DD] is provided within the context of Residential Supports, it may be documented using the CAP-MR/DD Residential Support Grid found at the end of this Appendix;
- Personal Care Services [DD], unless provided by a home care agency that is following home care licensure rules;
- Residential Supports [CAP-MR/DD], must address Habilitation, Personal Care, and Support [see CAP-MR/DD Residential Support Grid at the end of this Appendix]
- Residential Treatment – Family Type - Level II;
- Respite – all categories, except for Institutional Respite, which shall follow the State Mental Retardation Centers' documentation requirements; and
- Supported Employment Services [CAP-MR/DD]

Purpose: The purpose of the grid is to provide a means to quickly capture the goal(s) addressed, the staff's intervention/activity and the assessment of the consumer progress toward the goals established.

1. **Page ___ of ___:** Number of sheets that will be needed per 15-day cycle will depend on how many goals the consumer has in the service plan.
2. **Consumer's Name:** Enter consumer's name as recorded in the consumer's medical record.
3. **Medicaid ID Number:** Enter the Medicaid ID number for all Medicaid-eligible individuals.
4. **Record Number:** Enter the consumer's medical record number.
5. **Month/Year:** Enter the month and year service was received by the consumer.
6. **Shift:** When appropriate, enter the shift for which the entries represent.
7. **Specify Service:** Enter the specific service for which the form is being used, i.e., Residential Treatment - Level II, Supported Employment [CAP-MR/DD], etc.
8. **Area Program/LME:** Enter the name of the area program/LME.
9. **Service Provider/Agency:** If the service is provided by an agency other than the area program/LME, enter the name of the provider/agency.

10. **Goal(s):** Enter the goal as stated in the consumer's service plan. The goal should be written as documented in the service plan.
11. **Key:** A key(s) utilizing letters shall be developed to reflect interventions/activities. A key(s) utilizing numbers shall be developed to reflect the assessment of the consumer's progress toward the goals. All keys developed shall be identified in a Key Menu.

On the grid in the Key box, identify in the top part of the box labeled "I", the key to be used to reflect the interventions/activities. On the bottom part labeled "A", the key to be used to reflect the assessment of the consumer's progress toward the goals.
12. **Numbered Boxes 1-15/16-31:** Each numbered box represents a day of the month. Number of boxes used will depend on how many days are in that particular month. Each box is divided into an upper half and a lower half. The top half of the box represents the intervention/activity provided- [noted as an I in top half of the key section] and the lower half [noted as an A] represents the assessment of the consumer/resident's progress toward the goals; Based upon the key identified in the Key box, assign a letter which represents the intervention/activity provided and a number which represents the assessment of consumer's progress toward goals. A number can be placed in front of the key used to signify how many interventions/activity(ies) staff made.
13. **Duration:** Enter the total amount of time spent performing the intervention(s) when required.
14. **Date:** Enter the date the documentation is initialed for services provided to the consumer.
15. **Initials:** The provider shall initial for each day he/she provides a service to the consumer. The initials shall correspond to the section on the back of the form called, All Staff Persons Working With This Individual Must Fill Out The Information Below.
16. **Comments:** Each entry shall be dated. This section is for additional information such as to further explain the intervention/activities or assessment of consumer's progress toward goals.
17. **All Staff Persons Working With This Individual Must Fill Out The Information Below:** A staff person working with the consumer shall complete this section which includes the staff person's printed name, full signature, and initials.

North Carolina Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services

Note: This sample grid may only be used for Behavioral Health Prevention Education Services in Selective and Indicated Populations, Day Supports [CAP-MR/DD], Home and Community Supports [CAP-MR/DD], Personal Care [DD], Personal Care [CAP-MR/DD], Residential Treatment – Family Type [Level II], Respite [except for Institutional Respite], and Supported Employment Services [CAP-MR/DD].

Name of Individual: _____ Medicaid ID#: _____ Record #: _____ Month/Year: _____

Specify Service: _____ Area Program/LME: _____ Service Provider/ Agency: _____

Goals	Key	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	(I)																
	(A)																
	(I)																
	(A)																
	(I)																
	(A)																
Duration [when required]:																	
Date:																	
Initials:																	

Note: This sample grid may only be used for Behavioral Health Prevention Education Services in Selective and Indicated Populations, Day Supports [CAP-MR/DD], Home and Community Supports [CAP-MR/DD], Personal Care [DD], Personal Care [CAP-MR/DD], Residential Treatment – Family Type [Level II], Respite [except for Institutional Respite], and Supported Employment Services [CAP-MR/DD].

Specify Service: _____ Area Program/LME: _____ Service Provider/ Agency: _____

[illegible]

ALL STAFF PERSONS WORKING WITH THIS INDIVIDUAL MUST FILL OUT THE INFORMATION BELOW		
Staff Name (Please Print)	Staff Signature	Initials

North Carolina Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services

Note: This sample grid may only be used for Behavioral Health Prevention Education Services in Selective and Indicated Populations, Day Supports [CAP-MR/DD], Home and Community Supports [CAP-MR/DD], Personal Care [DD], Personal Care [CAP-MR/DD], Residential Treatment – Family Type [Level II], Respite [except for Institutional Respite], and Supported Employment Services [CAP-MR/DD].

Name of Individual: _____ Medicaid ID#: _____ Record #: _____ Month/Year: _____

Specify Service: _____ Area Program/LME: _____ Service Provider/ Agency: _____

Goals	Key	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	(I)															
	(A)															
	(I)															
	(A)															
	(I)															
	(A)															
Duration [when required]:																
Date:																
Initials:																

Note: This sample grid may only be used for Behavioral Health Prevention Education Services in Selective and Indicated Populations, Day Supports [CAP-MR/DD], Home and Community Supports [CAP-MR/DD], Personal Care [DD], Personal Care [CAP-MR/DD], Residential Treatment – Family Type [Level II], Respite [except for Institutional Respite], and Supported Employment Services [CAP-MR/DD].

Specify Service: _____ Area Program/LME: _____ Service Provider/ Agency: _____

ALL STAFF PERSONS WORKING WITH THIS INDIVIDUAL MUST FILL OUT THE INFORMATION BELOW		
Staff Name (Please Print)	Staff Signature	Initials

Name:	1. Date of Service 2. Identification of Recipient – if different from the client 3. Purpose of Contact
Medicaid ID Number:	4. Description of Intervention(s) 5. Effectiveness of the Intervention(s)
Record Number:	6. Duration of the Service - All periodic, as required by the specific service, or as otherwise required 7. Professional Signature - Degree, credentials, or licensure Paraprofessional Signature – Position

[illegible]

NAME:		MEDICAID ID #:		RECORD NUMBER:	
Date	Duration	Instructions: Briefly state purpose of contact, describe the intervention(s), and the effectiveness of the intervention(s).			*Signature Required
		PURPOSE OF CONTACT:			
		DESCRIPTION OF THE INTERVENTION(S):			
		EFFECTIVENESS OF THE INTERVENTION(S):			
		PURPOSE OF CONTACT:			
		DESCRIPTION OF THE INTERVENTION(S):			
		EFFECTIVENESS OF THE INTERVENTION(S):			
		PURPOSE OF CONTACT:			
		DESCRIPTION OF THE INTERVENTION(S):			
		EFFECTIVENESS OF THE INTERVENTION(S):			
		PURPOSE OF CONTACT:			
		DESCRIPTION OF THE INTERVENTION(S):			
		EFFECTIVENESS OF THE INTERVENTION(S):			

* For professionals - signature, credentials, degree or licensure; for paraprofessionals - signature and position

Service Notes

NC Division of Mental Health, Developmental
Disabilities, and Substance Abuse Services

Individual:		Medicaid ID#:	Record Number:
Date:		*Shift/Duration of Service:	
Purpose of Contact:			
Intervention(s) [what you did]:			
Effectiveness of the Intervention(s):			
*Signature Required			
Date:		*Shift/Duration of Service:	
Purpose of Contact:			
Intervention(s) [what you did]:			
Effectiveness of the Intervention(s):			
*Signature Required			
Date:		*Shift/Duration of Service:	
Purpose of Contact:			
Intervention(s) [what you did]:			
Effectiveness of the Intervention(s):			
*Signature Required			

* For professionals – signature, credentials, degree or licensure; for paraprofessional - signature & position

Psychosocial Rehabilitation [PSR] Daily Notes

Name of Individual: _____ Medicaid ID Number: _____ Record Number: _____

Date	Duration - Time spent performing the interventions	Instructions: Briefly state purpose of contact, description of intervention/activity, and the effectiveness of the intervention/activity.	Staff Signature/Position
		<p>Purpose of Contact: [Individual's goals may be pre-printed here.]</p> <p>The following Interventions/Activities were provided to the member and participation was encouraged, monitored and/or modeled by staff: <input type="checkbox"/>Pre-vocational <input type="checkbox"/>Recreation/Leisure <input type="checkbox"/>Community Living <input type="checkbox"/>Social Relationships <input type="checkbox"/>Educational <input type="checkbox"/>Personal Care/Daily Living <input type="checkbox"/>Other _____</p> <p>Effectiveness of the Interventions:</p>	
		<p>Purpose of Contact: [Individual's goals may be pre-printed here.]</p> <p>The following Interventions/Activities were provided to the member and participation was encouraged, monitored and/or modeled by staff: <input type="checkbox"/>Pre-vocational <input type="checkbox"/>Recreation/Leisure <input type="checkbox"/>Community Living <input type="checkbox"/>Social Relationships <input type="checkbox"/>Educational <input type="checkbox"/>Personal Care/Daily Living <input type="checkbox"/>Other _____</p> <p>Effectiveness of the Interventions:</p>	

CAP-MR/DD RESIDENTIAL SUPPORT GRID [May be used for CAP-MR/DD Personal Care if provided in conjunction with Residential Support]

Consumer Name: _____ Medicaid ID #: _____ Record #: _____ Month/Year: _____

Specify Services: _____ LME: _____ Service Provider/Agency: _____

Date:	Eating	Bathing	Dressing	Personal Hygiene	Ambulation	Health Monitoring				COMMENTS
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
ALL STAFF PERSONS WORKING WITH INDIVIDUAL MUST FILL OUT THIS INFORMATION BELOW										
Staff Name [Please Print]							Staff Signature			Initials

CAP-MR/DD RESIDENTIAL SUPPORT GRID [May be used for CAP-MR/DD Personal Care if provided in conjunction with Residential Support]

Consumer Name: _____ Medicaid ID #: _____ Record #: _____ Month/Year: _____

Specify Services: _____ LME: _____ Service Provider/Agency: _____

Date:	Eating	Bathing	Dressing	Personal Hygiene	Ambulation	Health Monitoring				COMMENTS
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
ALL STAFF PERSONS WORKING WITH INDIVIDUAL MUST FILL OUT THIS INFORMATION BELOW										
Staff Name [Please Print]							Staff Signature			Initials

APPENDIX E

Accessing Care: A Flow Chart for New Medicaid and New State Funded Consumers

ACCESSING CARE: A Flow Chart for New Medicaid and New State Funded Consumers



= Client Choice

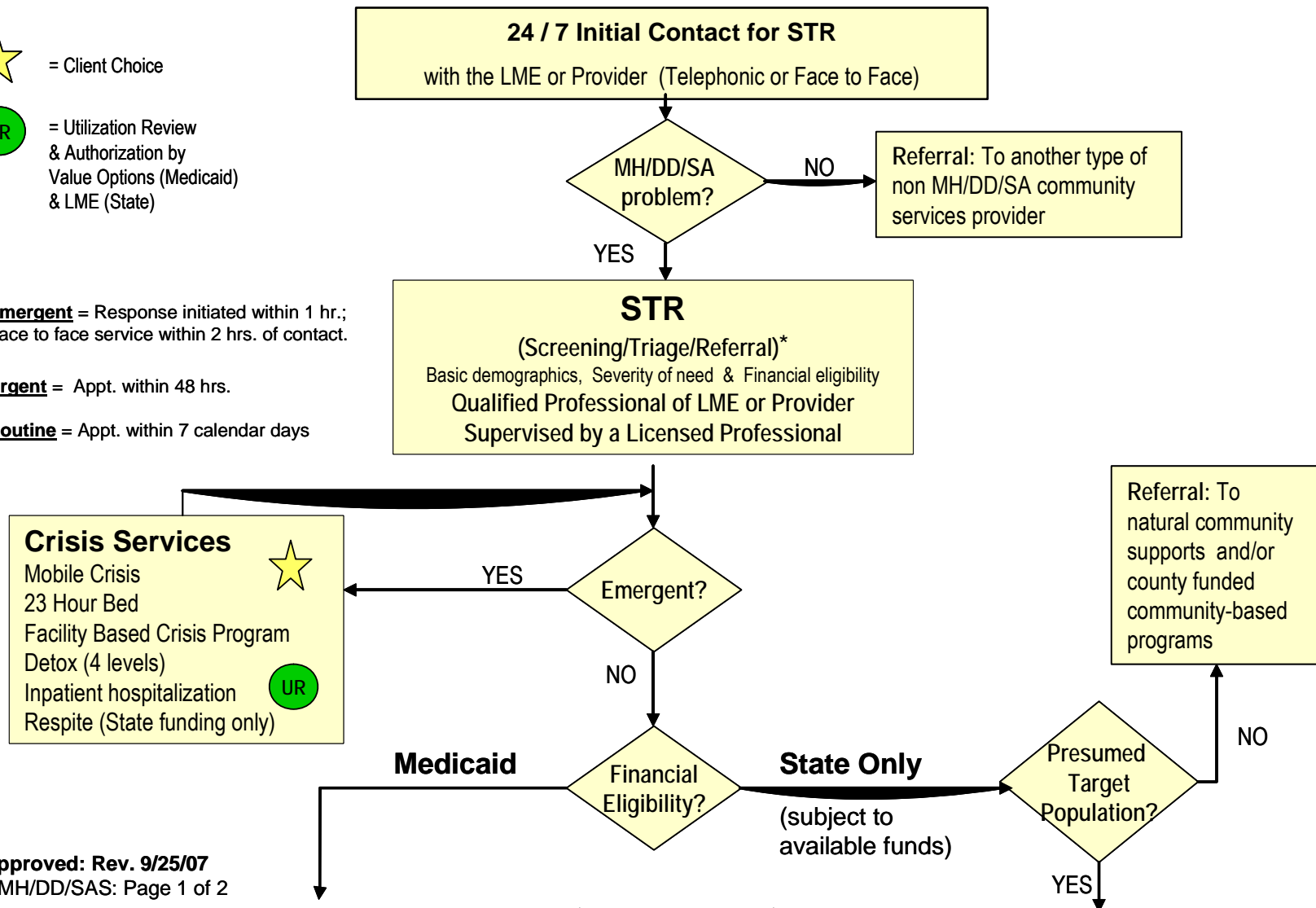


= Utilization Review
& Authorization by
Value Options (Medicaid)
& LME (State)

Emergent = Response initiated within 1 hr.;
Face to face service within 2 hrs. of contact.

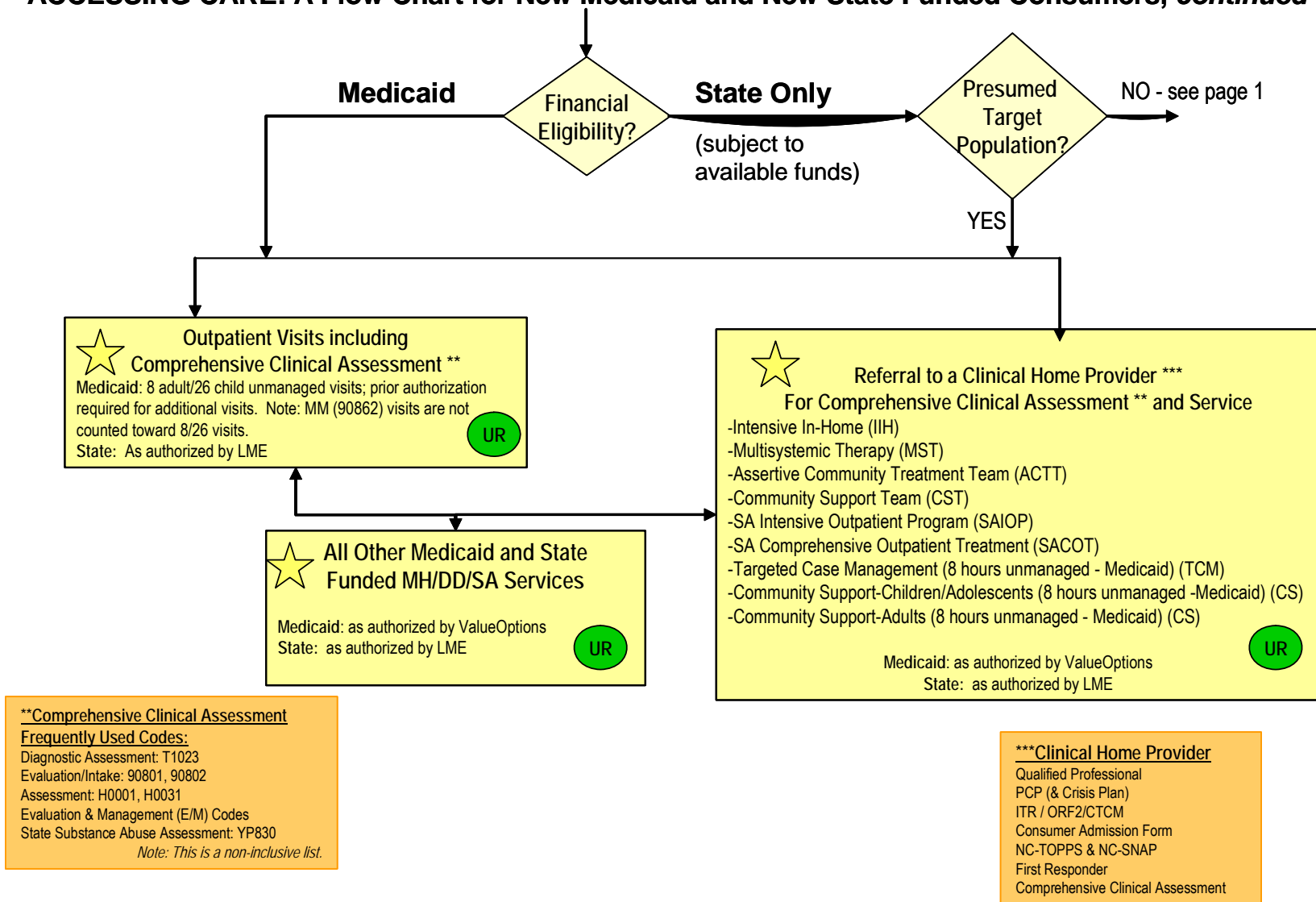
Urgent = Appt. within 48 hrs.

Routine = Appt. within 7 calendar days



(Continued on Page 2)

ACCESSING CARE: A Flow Chart for New Medicaid and New State Funded Consumers, *continued*



Approved: Rev. 9/25/07
DMH/DD/SAS: Page 2 of 2

**At a minimum, an Urgent response is required for SA consumers.
EPSDT is considered through the process.*

APPENDIX F

Service Duration Table

SERVICE DURATION TABLE

*Services that Require Duration - Time Spent Performing the Intervention(s) - In Service Notes

- ▶ All Periodic Services, except those that are billed on a per event basis, including, but not limited to:
 - ACTT
 - Community Support for Adults
 - Community Support for Children
 - Community Support Team
 - Intensive In-Home Services
 - Mobile Crisis Management
 - Multi-Systemic Therapy
- ▶ Ambulatory Detoxification
- ▶ Child and Adolescent Day Treatment
- ▶ Medically Supervised or ADACT Detoxification/Crisis Stabilization
- ▶ Non-Hospital Medical Detoxification
- ▶ Opioid Treatment
- ▶ Partial Hospitalization
- ▶ Professional Treatment Services in Facility-Based Crisis Programs
- ▶ Psychosocial Rehabilitation
- ▶ SACOT
- ▶ SA Halfway House
- ▶ SAIOP
- ▶ SA Medically Monitored Community Residential Treatment
- ▶ SA Non-Medical Community Residential Treatment
- ▶ Social Setting Detoxification

* This is not an exhaustive listing, but it does include most of the services that have this requirement.

Source Documents: For all the services listed above, the duration requirement can be found in at least one of the following documents and its corresponding link:

- ▶ Medicaid Clinical Coverage Policy Number 8A
<http://www.ncdhhs.gov/dma/bh/8A.pdf>
- ▶ Medicaid State Plan
<http://www.ncdhhs.gov/dma/plan/sp.pdf>
- ▶ DMH/DD/SA Service Definitions – March 27, 2006
<http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdef3-27-06rev.pdf>

APPENDIX G

General Statute for Minor Consent

Appendix G

General Statute for Minor Consent

G.S. § 90-21.5 - Minor's Consent Sufficient for Certain Medical Health Services

1. Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. § 130-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. § 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. § 122C-222.
2. Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.

APPENDIX H

Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Populations

Appendix H

Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Populations

Behavioral Health Prevention Education Services for children and adolescents who meet eligibility for selective and indicated population criteria are designed to prevent or delay the first use of substances, or to reduce or eliminate the use of substances. This service is provided in a group modality and is intended to meet the substance abuse prevention and/or early intervention needs of participants with identified risk factors for substance abuse problems [Selective] and/or with identified early problems related to substance use [Indicated]. Participants in Behavioral Health Prevention Education Services have identified risk factors or show emerging signs of use and the potential for substance abuse. The most typical program has a provider working directly with participants or parents [in a group setting] in a wide variety of settings including naturally occurring settings [school or community, etc.] on reducing known risk factors and/or enhancing protective factors that occur in that setting. Services are designed to explore and address the individual's behaviors or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of substance use. This service includes education and training of caregivers and others who have a legitimate role in addressing the risk factors identified in the service plan. This service includes, but is not limited to, children of substance abuser groups, education services for youth, parenting/family management services, peer leader/helper programs, and small group sessions. This service is preventive in nature and is not intended for individuals who have been determined to have a diagnosable substance abuse or mental health disorder which requires treatment. This service is time-limited, based on the duration of the curriculum-based program used. A provider is required to utilize an evidenced-based program in one of three nationally-approved categories: Promising Programs, Effective Programs, and Model Programs.

The Behavioral Health Prevention Education Services documentation shall be required for all children and adolescents receiving substance abuse selective and indicated prevention services and shall meet the following minimum requirements:

- **Documentation of Child and Adolescent Risk Profile:** Documentation of the findings of a child or adolescent risk profile that identifies one or more risk factors for substance abuse.
- **Assessment and Plan:**
 1. The Assessment of the participant shall include:
 - a. Documentation of the findings on a child or adolescent risk profile that identifies one or more designated risk factors for substance abuse;
 - b. Documentation of individual risk factor(s), history of substance use, if any, a description of the child's or adolescent's current substance use patterns, if any, and attitudes toward use; and
 - c. Other relevant histories and mental status that are sufficient to rule out other conditions suggesting the need for further assessment and/or treatment for a substance abuse or dependence diagnosis and/or a co-occurring psychiatric diagnosis.

2. The Plan shall:
 - a. Be based on an identification of the child's, adolescent's, and/or family's problems, needs, and risk factors, with recognition of the strengths, supports, and protective factors;
 - b. Match the child or adolescent risk profile with appropriate evidence-based Selective or Indicated Substance Abuse Prevention goals that address the child's or adolescent's and/or family's knowledge, skills, attitudes, intentions, and/or behaviors; and
 - c. Be signed by the participant and the parent/guardian, as appropriate, prior to the delivery of services.
 3. Following the delivery of each service, the minimum standard for documentation in the service record shall be a Service Grid which includes:
 - a. Identification of the evidence-based program being implemented;
 - b. Full date and duration of the service that was provided;
 - c. Listing of the individual child or adolescent and/or his or her family members that were in attendance;
 - d. Identification of the curriculum module delivered;
 - e. Identification of the module goal;
 - f. Identification of the activity description of the module delivered;
 - g. Initials of the staff member providing the service which shall correspond to a signature with credentials identified on the signature log section of the Service Grid; and
 - h) In addition to the above, notation of significant findings or changes in the status of the child or adolescent that pertain to the appropriateness of provision of services at the current level of care and/or the need for referral for other services shall be documented.
- **Consent for Participation:** In all circumstances, the child or adolescent shall sign consent for participation in behavioral health prevention education services.
 - **Service Grid:** A service grid shall include a notation following the delivery of each service and shall include the date and duration of the service that was provided, a listing of the individual child or adolescent and/or his or her family members that were in attendance, an identification of the evidence-based program module and service type, session goal, standard activity description, and initials of the staff member providing the service. The initials shall correspond to a signature with credentials identified on the signature log section of the service grid. Also to be documented, as appropriate, shall be a special notation of any child or adolescent significant findings or changes in status that pertain to the provision of services at the current level of care or the need for referral for other services.
 - **Individual and Family Outcomes:** Documentation shall include the findings of the standardized pre-tests and post-tests associated with the evidence-based program being implemented, and the individual and/or family outcomes resulting from the program intervention.

APPENDIX I

Glossary

Glossary

ACCESS - An array of treatments, services and supports is available; individuals know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.

ACCREDITATION - Certification by an external entity that an organization has met a set of standards.

ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOL [ADETS] - An approved curriculum which shall:

1. Include 10 to 13 contact hours in a classroom setting;
2. Be provided by area programs or their designated agencies with certified ADETS instructors; and
3. Be designed for persons:
 - a. who have only one DWI conviction [lifetime];
 - b. whose assessment did not identify a "Substance Abuse Handicap;" and
 - c. whose alcohol concentration was .14 or less.

AMERICAN SOCIETY OF ADDICTION MEDICINE [ASAM] PLACEMENT CRITERIA - The Patient Placement Criteria for the Treatment of Substance-Related Disorders produced by the American Society of Addiction Medicine. These criteria are used as guides for the provision of substance abuse treatment that is appropriate for the individual.

AREA AUTHORITY/COUNTY PROGRAM - A program that is certified by the DHHS Secretary to manage, oversee and sometimes directly provide mental health, developmental disabilities, and substance abuse services in a specified geographic area. Most Area Programs have already changed or will soon be changing to Local Management Entities [LME].

ARRAY OF SERVICES - Group of services available.

ASSESSMENT - A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability, or substance abuse treatment services and/or supports according to applicable requirements.

BASIC BENEFITS - Traditional behavioral health services under the Medicaid State Plan, including physician services, often referred to as outpatient treatment or medication management services, which include those services covered in Medicaid Clinical Coverage Policy 8C – Outpatient Behavioral Health Services Provided by Direct Enrolled Providers. These services may also be provided to individuals who meet medical necessity criteria for MH/DD/SA Community Intervention Services, but for whom services are limited to outpatient and/or medication management services only. Documentation requirements for these services are beyond the scope of this manual.

BEST PRACTICE(S) - Interventions, treatments, services, or actions that have been shown to generate the best outcomes or results. The terms, "evidence-based" or "research-based" may also be used.

BLOCK GRANT - Funds received from the federal government [or others], in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. The Division of MH/DD/SAS receives three block grants: the Mental Health Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Social Services Block Grant.

CAP-MR/DD - The acronym for the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities. CAP-MR/DD provides home and community-based care as an alternative to care in an Intermediate Care Facility for persons with Mental Retardation/Developmental Disabilities [ICF-MR].

CAP-MR/DD WAIVER - A Medicaid community care funding source for persons with MR/DD who require an ICF/MR level of care that offers specific services in the community.

CATCHMENT AREA - The geographic area of the state served by a specific county/area program or LME.

CENTERS FOR MEDICARE AND MEDICAID SERVICES [CMS] - The US federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program. This agency approves the North Carolina Medicaid Plan.

CLAIM - An itemized statement of services, performed by a provider network member or facility, which is submitted for payment.

CLINICAL HOME - Lead service provider agency that has the designated responsibility for the coordination of a person's services. Qualified Professionals carry out the clinical home functions which include the responsibility for assuring the completion of a comprehensive clinical assessment, the development of the PCP, and ensuring that the appropriate behavioral health services and supports are in place when individuals need them. Clinical home provider agencies are specifically responsible for the following functions:

- Carried out by a Qualified Professional [QP];
- Assurance that a comprehensive clinical assessment is completed upon service entry [individuals who are new to the MH/DD/SA service system];
- Development of the PCP & Crisis Plan;
- Submission of the ITR/OFR-2/CTCM Form;
- Submission of the Consumer Admission Form, NC-TOPPS & NC-SNAP; and
- Assurance of first response to emergencies or crises.

Typically, the clinical home provider is the provider agency that has the most experience with and knowledge of the individual's needs, preferences, and progress. All clinical home providers of Medicaid-funded services are endorsed by the LME for enrollment with DMA.

COMMUNITY INTERVENTION SERVICE [CIS] AGENCY - Term used as a provider agency classification to confirm that the agency has met the eligibility criteria for entering into a participation agreement with the Division of Medical Assistance to provide certain specific services that have been endorsed or approved by the entity [the LME for MH/DD/SAS] responsible for determining such eligibility. Once approval or endorsement has been awarded, the service provider agency may then achieve approved status as a Medicaid Provider of Community Intervention Services and enter into a participation agreement to provide the services.

COMMUNITY INTERVENTION SERVICES - Specific MH/DD/SA services that are delineated in Clinical Coverage Policy 8A and subject to provider endorsement by the LME and direct enrollment with DMA.

COMPREHENSIVE CLINICAL ASSESSMENT - An intensive clinical and functional face-to-face evaluation of an individual's presenting mental health, developmental disability, and/or substance abuse condition that results in the issuance of a written report, providing the clinical basis for the development of a Person-Centered Plan [PCP] and recommendations for services/supports/treatment.

CONFIDENTIAL INFORMATION - Any information, whether recorded or not, relating to an individual served by a facility that was received in connection with the performance of any function of the facility. Confidential information does not include statistical information from reports and records or information regarding treatment or services shared for training, treatment, habilitation, or monitoring purposes that does not identify individuals either directly or by reference to publicly known or available information.

CONFIDENTIALITY - Keeping information private. Allowing records or information to be seen or used only by those with legal rights or permission.

CONSENT - Giving approval or agreeing to something. For example, in education, a parent must give consent before a child can be evaluated or placed in a special program. Consent is usually documented in writing and may be given for regular treatment, emergency medical care, and participation as a subject in a research project. The individual giving consent in a particular situation must have the legal authority to do so.

CONSENT FOR PARTICIPATION - A signed agreement to take part in treatment required for children and adolescents receiving substance abuse treatment.

CONSULTATION - Information shared between or among peers or professionals to increase the ability to manage challenging circumstances.

CONSUMER DATA WAREHOUSE [CDW] - A database containing data regarding demographic, clinical outcomes, and satisfaction data regarding individuals served by MH/DD/SA service providers. The data stored in the CDW is the main source of information regarding block grant programs and to fulfill legislative requests. The information is also used for planning and evaluation of services.

CORE SERVICES - Services that are necessary for the basic foundation of any service delivery system. Core services under the Division of MH/DD/SAS are of two types: front-end service capacity, such as screening, assessment, triage, emergency services, service coordination, and referral; and indirect services, such as prevention, education, and consultation at a community level. Membership in a target population is not required to access a core service.

COST SUMMARY - A document summarizing the costs of CAP-MR/DD services for a CAP-MR/DD Program participant. The cost summary must match all waiver services that are reflected in the Plan of Care and cover a twelve-month period.

COUNTERSIGNATURE - Additional signatures, other than the signature of the individual who actually provided the service. Countersignatures are sometimes used to indicate the review and approval of documentation within the context of clinical supervision. Countersignatures are not required by the State, but countersignature entries in the service records may be required based upon the provider agency's policy when such a policy exists.

CRISIS PLAN - A crisis plan is developed as part of the individual's Person-Centered Plan and is designed to facilitate stabilization in response to stressful life events that may seriously interfere with a person's ability to cope or manage his or her life. The event may be emotional, physical, or situational in nature. The event is the perception of and response to the situation, not the situation itself. Essential elements include:

1. A proactive component that identifies early known warning signals and triggers of an impending crisis.
2. An intervention component for steps when the individual is experiencing emotional, physical, or situational difficulties that interfere with his/her ability to manage immediate needs without assistance.
3. Information about the process or procedure which will be followed when a crisis event or emergency situation occurs, such as who to call as First Responder, what actions to take with the individual in crisis, and what crisis services or hospitals should be used.

DAY/NIGHT SERVICES - Services provided on a regular basis, in a structured environment that is offered to the same individual for a period of three or more hours within a 24-hour period. This term generally refers to services that are a part of daily or regular group programming, but are not 24-hour residential services. Some examples of Day/Night Services are: Substance Abuse Intensive Outpatient Program, Day Treatment Programs and Partial Hospitalization, Developmental Day, Psychosocial Rehabilitation, ADVP, Supported Employment, Community Rehabilitation Program [Sheltered Workshop], and Day/Evening Activity.

DEPARTMENT OF HEALTH AND HUMAN SERVICES [DHHS] - The North Carolina agency that oversees state government human services programs and activities.

DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which:

1. is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
3. is likely to continue indefinitely;
4. results in substantial functional limitations in three or more of the following areas of major life activity; self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
5. reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated; or
6. when applied to children from birth through four years of age, may be evidenced as a developmental delay.

DIAGNOSTIC AND STATISTICAL MANUAL [DSM-IV-TR] - A reference book, published by the American Psychiatric Association, of special codes that identify and describe MH/DD/SA disorders and their symptoms.

DIAGNOSTIC ASSESSMENT - An intensive clinical and functional face to face evaluation of an individual's mental health or substance abuse condition that results in the issuance of a Diagnostic Assessment report with a recommendation regarding whether the individual meets target population criteria, and provides the basis for the development of an initial Person-Centered Plan.

DISCHARGE PLAN - A document generated at the time service is terminated that contains recommendations for further services designed to enable the person to live as normally as possible.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES [DMH/DD/SAS] - A division of the State of North Carolina, Department of Health and Human Services, responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

DMA - The acronym for the North Carolina Division of Medical Assistance located in the Department of Health and Human Services. This is the agency that operates the Medicaid Program for North Carolina.

DRUG EDUCATION SCHOOL [DES] - A prevention and intervention service which provides an educational program for drug offenders as provided in the North Carolina Controlled Substances Act and Regulations.

DURATION - The total amount of time spent performing intervention(s). When applicable, this amount of time is documented in service notes and is billed within payor reimbursement guidelines for the service. Duration is required to be recorded:

- for all periodic services, unless the periodic service is billed on a per event basis;
- for all services as required by the Medicaid State Plan;
- for all services as required by Medicaid Clinical Coverage Policies; or
- whenever duration is required by the service definition.

EARLY PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES [EPSDT] - Services provided under Medicaid to children under age 21 to determine the need for mental health, developmental disabilities or substance abuse services. Providers are required to provide needed service identified through screening.

ELECTRONIC RECORD - A computer-based service record that resides in a system specifically designed to support users by providing accessibility to complete and accurate data, alerts, reminders, clinical support systems, links to medical knowledge, and other aids. A record is not considered computer-based if it is only stored electronically in a computer as a word-processing file and not as a part of an electronic database.

ELECTRONIC SIGNATURE - A computer process whereby service documentation authorship and/or approval can be documented by a specific individual. Guidelines for electronic signature must be followed to ensure proper review of documentation, secure passwords, and individual documented agreement with the electronic signature guidelines.

EMPLOYEE ASSISTANCE PROGRAM [EAP] - A worksite-based program designed to assist: [1] work organizations in addressing productivity issues, and [2] employees in identifying and resolving personal concerns, including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance.

EVALUATION - More in-depth than an assessment, examination of specific needs or problems by professionals using specific evaluation tools.

EVIDENCE-BASED PRACTICE - Evidence Based Practice [EBP] refers to a research-based treatment approach or protocol that has been found to have clinical efficacy and effectiveness for individuals with certain emotional or behavioral challenges.

FIRST RESPONDER - The provider designated in the PCP to provide crisis response on a 24/7/365 basis. Typically, the first responder is the provider who has the most sustained contact and familiarity with the clinical dynamics of the individual being served.

FOLLOW-UP - A process of checking on the progress of a person who has completed treatment or other services, has been discharged, or has been referred to other services and supports.

GUARDIAN - An individual who has been given the legal responsibility to care for a child or adult who is incapable of taking care of themselves due to age or lack of capacity. The appointed individual is often responsible for both taking care of the child or incapable adult and their affairs. A legal guardian may provide permission for an individual to receive treatment. Also, a person appointed as a guardian of the person or general guardian by the court under Chapters 7A or 35A or former Chapters 33 or 35 of the General Statutes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT [HIPAA] - A federal Act that protects people who change jobs, are self-employed, or who have pre-existing conditions. The Act aims to make sure that prospective or current recipient of services are not discriminated against based on health status. HIPAA also protects the privacy and security of an individual's protected health information.

HOME CARE AGENCY - An agency that is licensed by the Division of Facility Services [DFS] to provide home care services and directly-related medical supplies and appliances to an individual at his home. Home care services include nursing care; physical, occupational, or speech therapy; medical social services; "hands-on" in-home aide services; infusion nursing services; and assistance with pulmonary care, pulmonary rehabilitation, or ventilation.

INCIDENT AND DEATH REPORT - A report of any incident, unusual occurrence, medication error, or death of a person that occurs while an individual is under the care of a service provider. In order to maintain authorization to provide publicly-funded MH/DD/SA services and good licensure status, a provider must follow the requirements for incident response and reporting as set forth in 10A NCAC 27G .0600, in accordance with Section 4.5 of NC Session Law 2002-164 [Senate Bill 163]. For full details on these requirements, consult the Administrative Code and the DHHS Incident and Death Reporting Form QM02 and Manual, which can be found under "Forms" at: <http://www.ncdhs.gov/mhddsas/statpublications/manualsforms/index.htm>

INDEPENDENT PRACTITIONER - A licensed practitioner who does not need to be endorsed by an LME and who may be directly enrolled with Medicaid to provide basic benefit services.

INDIVIDUALIZED EDUCATION PROGRAM [IEP] - A written plan for a child with special education needs. The plan is based on results from an evaluation and is developed by a team that includes the child's parents, teachers, other school representatives, specialists, and the child when appropriate.

INPATIENT - A person who is hospitalized. An inpatient facility may be hospital or non-hospital based, such as PRTF.

INTEGRATED PAYMENT AND REPORTING SYSTEM [IPRS] - An electronic, web-based system used to track, pay and report on all claims submitted by providers for services rendered.

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES [ICF MR/DD] - A facility that provides ICF level of care to eligible persons who have mental retardation or developmental disabilities.

INTERNATIONAL CLASSIFICATION OF DISEASES [ICD-9-CM] - The International Classification of Diseases, 9th Revision, Clinical Modification, Volumes 1 and 2, US Department of Health and Human Services, US Government Printing Office, Washington, DC. This document provides diagnostic categorization and coding of illnesses.

LEGALLY RESPONSIBLE PERSON - When applied to an adult, who has been adjudicated incompetent, a guardian; when applied to a minor, a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment; or when applied to an adult who is incapable as defined in G.S. 122C-72(c) and who has not been adjudicated incompetent, a health care agent named pursuant to a valid health care power of attorney as prescribed in Article 3 of Chapter 32 of the General Statutes.

LICENSURE - A state or federal regulatory system for service providers to protect the public health and welfare. Examples of licensure include licensure of individuals by professional boards, such as the NC Psychology Board, or the NC Substance Abuse Professional Certification Board. Examples of licensure also include licensure of facilities used to provide MH/DD/SA services by the NC Division of Facility Services.

LOCAL MANAGEMENT ENTITY [LME] - The local agency that plans, develops, implements, and monitors services within a specified geographic area, according to requirements of the Division of MH/DD/SAS. Includes developing a full range of services that provides inpatient and outpatient treatment, services, and/or supports for both insured and uninsured individuals. See also AREA AUTHORITY/COUNTY PROGRAM.

MASTER INDEX - This index is a file of persons served. This list shall be permanently maintained manually or electronically by all service provider agencies.

MEDICAID - A jointly-funded federal and state program that provides hospital and medical expense coverage to low-income individuals, certain elderly people, and people with disabilities.

MEDICAL NECESSITY - Criteria established to ensure that treatment is necessary and appropriate for the condition or disorder for which the treatment is provided in order to meet the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the individual. In order for a service to be eligible for reimbursement by Medicaid or the State, the individual must have an established diagnosis reflecting the medical necessity criteria inherent in the service.

MEDICARE - A federal government hospital and medical expense insurance plan primarily for elderly people and people with disabilities.

MINOR [OR UNEMANCIPATED MINOR] - Any person under the age of 18 who has not been married or has not been emancipated pursuant to Article 35 of Chapter 7B of the General Statutes.

MODIFIED RECORD - A clinical service record which has requirements that are either different from those that are usually associated with a full clinical service record, or which contains only certain components of a full service record. The use of modified records is limited to those approved by DMH/DD/SAS, and used only if there are no other services being provided. When an individual receives additional services, then a full service record shall be merged into the full service record. Modified records may only be used for: Respite [if respite is the only service being provided];

Behavioral Health Prevention Education Services for Children & Adolescents in Selective and Indicated Prevention Services, Universal Prevention Services, and other services, if approved by the Division.

MR-2 [OR MR2] - A form used in the CAP/MR-DD program. The ICF-MR Level of Care determination is assessed and documented on the MR2 form by a physician or clinical psychologist licensed by the State of North Carolina. The physician/licensed psychologist providing the assessment will complete the MR2 for individuals that, based on the assessment results, appear to meet the ICF-MR level of care.

NORTH CAROLINA ADMINISTRATIVE CODE [NCAC] - State rules and regulations. The rules governing MH/DD/SA service can be found in 10A NCAC, Chapters 26-31, linked here: <http://reports.oah.state.nc.us/ncac.asp?folderName=\Title%2010A%20-%20Health%20and%20Human%20Services> .

NORTH CAROLINA TREATMENT OUTCOMES AND PROGRAM PERFORMANCE SYSTEM [NC-TOPPS] - Refers to the program by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services [DMH/DD/SAS] measures outcomes and performance for Substance Abuse and Mental Health service recipients. NC-TOPPS captures key information on a person's current episode of treatment, aids in evaluation of active treatment services, and provides data for meeting federal performance and outcome measurement requirements.

OUTCOMES - At the individual level, events used to determine the extent to which service recipients improve their levels of functioning, improve their quality of life, or attain personal life goals as a result of treatments, services and/or supports provided by the public and/or private systems. At the system level, outcomes are events used to determine if the system is functioning properly.

PENDING RECORD - A record that has the potential to become a full service record, once it is determined that the individual meets the requirements that call for the establishment of a full service record, and usually created when an individual presents for screening for possible services, or when there is insufficient, partial, or incomplete information available and a full service record cannot be established. A pending record may be used when there may have been some intervention, such as an initial screening, but the individual is not subsequently enrolled in active treatment. Services that are typically documented in a pending record include: Screening, Triage, and Referral; Court ordered consultation and/or evaluations that do not result in a subsequent MH/DD/SA service; Assertive Outreach; and Drop-In Center Services.

PERIODIC SERVICES - A service provided on an episodic basis, either regularly or intermittently, through short, recurring visits for persons with mental illness, developmental disabilities, or who are substance abusers.

PERSON-CENTERED PLANNING - An approach in which the individual directs his/her own planning process with the focus being on the expressed preferences, needs, and plans for his/her future. This process involves learning about the individual's whole life, not just the issues related to the person's disability. The process involves assembling a group of supporters, on an as-needed basis, who are selected by the individual with the disability and who have the closest personal relationship with them and are committed to supporting the person in pursuit of real life dreams. Those involved with the planning process are interested in learning who the person is as an individual and what he/she desires in life. The process is interested in identifying and gaining access to supports from a variety of community resources, one of which is the community MH/DD/SA service system that will assist the person in pursuit of the life he/she wants. Person-centered planning results in a written individual support plan.

PERSON-CENTERED-PLAN - An individualized and comprehensive plan that specifies all services and supports to be delivered to the individual eligible for mental health and/or developmental disability and/or substance abuse services according to NC Mental Health Reform requirements. A person-centered plan generates action or positive steps that the person can take towards realizing a better and more complete life. Plans also are designed to ensure that supports are delivered in a

consistent, respectful manner and offer valuable insight into how to assess the quality of services being provided.

PLAN OF CARE - For the CAP-MR/DD Waiver, the person-centered plan is called the Plan of Care. It is a means for people with disabilities or long-term care needs to exercise choice and responsibility in the development and implementation of their care plan. The individual directs the planning process that identifies strengths, capacities, desires and support needs.

PREVENTION - Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing to mental illness, developmental disabilities and substance abuse. Universal prevention programs reach the general population; selective prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; indicated prevention programs are designed for people who are already experiencing mental illness or addiction disorders.

PRIOR AUTHORIZATION - A managed care process that approves the provision of services before they are delivered. ValueOptions performs prior authorization for Medicaid funded services. State funded services that require prior authorization receive this from the LMEs.

PROTECTED HEALTH INFORMATION [PHI] - PHI is individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. This information must relate to 1) the past, present, or future physical or mental health, or condition of an individual; 2) provision of health care to an individual; or 3) payment for the provision of health care to an individual. If the information identifies or provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information. See Part II, 45 CFR 164.501.

PROVIDER - A person or an agency that provides MH/DD/SA services, treatment, supports.

PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES SYSTEM - The network of managing entities, service providers, government agencies, institutions, advocacy organizations, commissions and boards responsible for the provision of publicly-funded services to individuals.

QUALIFIED PROFESSIONAL - Any individual with appropriate training or experience in the fields of mental health, developmental disabilities, or substance abuse treatment as specified by the General Statutes or by rule.

QUALIFIED PROVIDER - A provider who meets the provider qualifications as defined by rules adopted by the Secretary of Health and Human Services.

QUALITY ASSURANCE [QA] - A process to assure that services are minimally adequate, individual rights are protected, and organizations are fiscally sound. QA involves periodic monitoring of compliance with standards. Examples include: establishment of minimum requirements for documentation, service provision, licensure and certification of individuals, facilities, and programs; and investigation of allegations of fraud and abuse. See also, QUALITY MANAGEMENT.

QUALITY IMPROVEMENT [QI] - A process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business.

QUALITY MANAGEMENT [QM] - A framework for assessing and improving services and supports, operations, and financial performance. Processes include: quality assurance, such as external review of appropriateness of documentation, monitoring, and quality improvement, such as design and implementation of actions to address access. See also QUALITY ASSURANCE AND QUALITY IMPROVEMENT.

RECIPIENT - A person authorized for Medicaid or other program or insurance coverage. Also, an individual receiving a given service.

RECORD RETENTION AND DISPOSITION SCHEDULE FOR STATE AND AREA FACILITIES -

This schedule determines the procedures for the management, retention, and destruction of records by the Division of MH/DD/SAS facilities, and the LMEs and their contractors. Please find link here: <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm10-3retentionupdated5-05.pdf>

REFERRAL - The process of establishing a link between a person and another service or support by providing authorized documentation of the person's needs and recommendations for treatment, services, and supports. It includes follow-up in a timely manner consistent with best practice guidelines.

SCREENING - An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for additional services. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it, whether or not they meet criteria for target or priority populations.

SCREENING, TRIAGE AND REFERRAL - This process involves a brief interview designed to first determine if there is a MH/DD/SA service need, the likely area[s] of need, as well as the immediacy of need [emergent, urgent, or routine]. The individual is then connected to an appropriate provider for services based upon the area and level of need indicated.

SERVICE GRID - A method of documentation of service provision that is approved for use for specific services.

SERVICE ORDER - Written authorization by the appropriate professional as evidence of the medical necessity of a given service.

SERVICE PROVIDER - Any person or agency giving some type of service to children or their families. A service provider, or service provider agency, is part of the provider community under Mental Health Reform.

SERVICE RECORD - A document that is required to demonstrate evidence of a documented account of all service provision to a person, including pertinent facts, findings, and observations about a person's course of treatment/habilitation and the person's treatment/habilitation history. The individual's service record provides a chronological record of the care and services which the individual has received and is an essential element in contributing to a high standard of care.

SERVICE RECORD NUMBER CONTROL REGISTER - This register controls the assignment of service record numbers. Any person admitted shall retain the same service record number on subsequent admission. This shall be permanently maintained manually or electronically by all service provider agencies.

STANDARDS - Activities generally accepted to be the best method of practice. Also, the requirements of licensing, certifying, accrediting, or funding groups.

STATE PLAN [DMH/DD/SAS] - The annually updated statewide plan that forms the basis and framework for MH/DD/SA services provided across the state.

STATE PLAN [NORTH CAROLINA MEDICAID] - All of the formal policies, processes, and procedures approved by the US federal agency Centers for Medicare & Medicaid [CMS] regarding the Medicaid Program in North Carolina. This includes approval of Medicaid services and service definitions.

TANGIBLE SUPPORTS - Concrete resources that are available as a part of the CAP-MR/DD Program to assist in improving an individual's level of functioning, for example, "Home Modifications."

TARGETED CASE MANAGEMENT - A service approved only for individuals with a developmental disability that involves locating, obtaining, coordinating, and monitoring social, habilitative, and

medical services, as well as other services and supports related to maintaining an individual's health, safety and well-being in the community.

TARGET POPULATIONS - A categorization in IPRS that applies to the classification of individuals who meet eligibility requirements in order to receive benefits for mental health, developmental disabilities, or substance abuse conditions, according to the North Carolina State Plan for Mental Health Reform. In general, individuals who meet Target Population eligibility are those with the most serious or severe unmet challenges and needs.

TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITIES [TASC] - A service designed to offer a supervised community-based alternative to incarceration or potential incarceration, primarily to individuals who are alcohol or other drug abusers, but also to individuals who are mentally ill or developmentally disabled and who are involved in crimes of a non-violent nature. This service provides a liaison between the criminal justice system and alcohol and other drug treatment and educational services. It provides screening, identification, evaluation, referral, and monitoring of alcohol or other drug abusers for the criminal justice system.

TWENTY-FOUR -HOUR FACILITY - A facility wherein a service is provided to the same individual on a 24-hour continuous basis, and includes residential and hospital facilities.

UTILIZATION MANAGEMENT [UM] - A process to regulate the provision of services in relation to the capacity of the system and the needs of individuals. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of individuals. UM is typically an externally-imposed process, based on clinically defined criteria.

UTILIZATION REVIEW [UR] - An analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. UR is typically an internally- imposed process that employs clinically established criteria.